STATE AND SCHOOL EMPLOYEES'

Life AND Health PLAN

Know Your Benefits

PLAN DOCUMENT
Revised January 2012

Includes Separate HIPAA Notice of Privacy Practices

IMPORTANT VENDOR ADDRESSES AND TELEPHONE NUMBERS

CLAIMS ADMINISTRATOR	**Blue Cross & Blue Shield of Mississippi (BCBSMS)** P.O. Box 23071 Jackson, MS 39225-3071 (800) 709-7881
PROVIDER NETWORK	**AHS State Network** P.O. Box 23070 Jackson, MS 39225 (800) 294-6307
MEDICAL MANAGEMENT/ UTILIZATION REVIEW PROGRAM	**ActiveHealth** 6501 Fiddler's Green Circle Suite 320 Greenwood Village, CO 80111 (866) 939-4721
PHARMACY BENEFIT MANAGER	**Catalyst Rx** Direct Member Reimbursement P.O. Box 1069 Rockville, MD 20849-1069 (866) 757-7839
PHARMACY MAIL ORDER PROGRAM	**Catalyst Rx Mail Order** P.O. Box 166 Avon Lake, OH 44012-9927
PLAN SPONSOR	**Health Insurance Management Board** **Department of Finance and Administration** **Office of Insurance** P.O. Box 24208 Jackson, MS 39225-4208 (601) 359-3411 (866) 586-2781 64-6000749 http://knowyourbenefits.dfa.state.ms.us
LIFE INSURANCE COMPANY	**Minnesota Life** 400 Robert Street North St. Paul, Minnesota 55101-2098 (866) 293-6047
WELLNESS AND HEALTH PROMOTION	**WebMD Health Services Group, Inc.** 2701 NW Vaughn St. Suite 700 Portland, OR 97210 (866) 789-4594

Services of legal process may be made on the agent listed below or the Plan Sponsor.

Attorney General of Mississippi
P.O. Box 220
Jackson, MS 39225

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Introduction

This *Plan Document* contains the official rules and regulations of the State and School Employees' Health Insurance Plan (Plan). This *Plan Document* replaces and supersedes all previously issued *Plan Documents*, *Plan Document Amendments*, *Summary Plan Descriptions,* and *Master Plan Documents*. When there are changes in benefits, a notice explaining the details of the changes will be issued. Notices of changes to the health Plan and life insurance coverage may be included in the Plan's *Know Your Benefits* newsletter.

Please take a moment to read through this booklet to become familiar with the information it contains. This *Plan Document* is a reference guide for questions on life and health benefits.

The Plan offers two coverage choices for active employees, COBRA participants, and non-Medicare eligible retirees: Base Coverage and Select Coverage. Each coverage type is independent of the other. Throughout this *Plan Document*, the term Plan refers to Base Coverage and Select Coverage unless otherwise noted.

The Plan includes a separate coverage level for Medicare eligible retirees, Medicare eligible surviving spouses, and Medicare eligible dependents of retirees and surviving spouses.

If you are, or will become in the next 12 months, a Medicare eligible retiree, Medicare eligible surviving spouse, or a Medicare eligible dependent of a retiree or surviving spouse, the availability of prescription drug coverage under Medicare will impact your prescription drug coverage under the Plan. Please refer to the Retiree Eligibility and Medical Coverage section for more details.

No verbal statements of any person will modify or otherwise affect the benefits or limitations and exclusions of the Plan, nor shall any such statements convey or void any coverage, or increase or reduce any benefits under the Plan.

This *Plan Document* does not create, nor is it intended to provide an employment contract between the State of Mississippi and any employee.

As provided by Mississippi state law, the State and School Employees Health Insurance Management Board (Board) has complete authority to control, operate, and manage the Plan. The Department of Finance and Administration, Office of Insurance is authorized by law to provide day-to-day management of the Plan. The Board has provided full discretion to the Office of Insurance to determine eligibility status, interpret Plan benefits and rules, and determine whether a claim should be paid or denied according to the provisions of the Plan set forth in this *Plan Document*. The Board reserves the right to amend, reduce, or eliminate any part of the Plan at any time.

Note: Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine unless the context clearly indicates the contrary.

How the Plan Works

A Self-Insured Plan

The Plan is a self-insured plan. When an organization manages a self-insured plan, it means that the organization (or in this case, the State) bears the financial responsibility for its own employee benefit plan. This means that the State is responsible for paying claims and other expenses associated with providing Plan participants with health care coverage. No vendor contracted by the Board insures or guarantees these self-insured benefits. The State, through the Board, determines the benefits and establishes the premiums. All costs are paid from the money collected in premiums. There is no direct State appropriation of funds to the Plan.

Medical Claims Administrator

The Medical Claims Administrator for the Plan is Blue Cross & Blue Shield of Mississippi (BCBSMS). BCBSMS is responsible for maintaining eligibility and processing medical claims for the Plan.

Medical Plan Choices

The Plan provides two types of coverage from which active employees, COBRA participants, non-Medicare eligible retirees, and non-Medicare eligible surviving spouses can choose: Base Coverage and Select Coverage. These coverage types are explained in this section.

The Plan includes a separate coverage level for Medicare eligible retirees, Medicare eligible surviving spouses, and Medicare eligible dependents of retirees and surviving spouses. Refer to the *Retiree Eligibility and Medical Coverage* section for more information.

Provider Network

The AHS State Network (Network) is a network of physicians, hospitals, and other health care providers. The Network is responsible for recruiting, credentialing, and communicating with providers. Providers participating in the Network agree to accept the allowable charge fees set by the Network and agree to file claims for Plan participants.

Participants may choose any covered participating or non-participating provider, primary care or specialist; however, using providers that participate in the Network provides participants the maximum benefits available through the Plan. Participants choosing to use providers that do not participate in the Network are responsible for paying any fees charged over the allowable charge, in addition to paying a higher annual deductible (for those participants under Select Coverage) and higher coinsurance amounts for covered services.

To find a participating provider, participants can access the Network directory through the Plan's website at http://knowyourbenefits.dfa.state.ms.us or call the Network at the telephone number

listed in this *Plan Document*. Provider participation in the Network may change from time to time. It is important for participants to verify provider participation prior to receiving services.

Medical Management/Utilization Review

ActiveHealth Management, Inc. (ActiveHealth) is the medical management administrator for the Plan. ActiveHealth performs medical management and utilization review services. Utilization review is a process to make sure that medical services are medically necessary, delivered in the most appropriate setting, reflective of the correct length of stay, and consistent with generally accepted medical standards. Certification requirements apply, regardless of whether a participant uses a participating or non-participating provider.

Certification is not required for those participants having Medicare or other primary coverage, unless the primary carrier does not cover the service. For additional information on services requiring certification, see the *Medical Management and Utilization Review* section.

Pharmacy Benefit Manager

Catalyst Rx is the pharmacy benefit manager for the Plan's prescription drug program. Catalyst Rx is responsible for:

- Developing and maintaining a network of participating pharmacies,
- Negotiating with pharmaceutical manufacturers,
- Managing the prescription drug mail order program,
- Developing a list of preferred drugs,
- Processing prescription claims from participating pharmacies, and
- Processing prescription claims when a participant files a paper claim.

Medicare eligible retirees, Medicare eligible surviving spouses, and Medicare eligible dependents of retirees and surviving spouses are not eligible for prescription drug benefits.

Motivating Mississippi – Keys to Living Healthy

Preventive Services

Benefits are provided at 100% of the allowable charge for certain wellness/preventive services. Refer to the *Well-Child Care* and *Wellness/Preventive Coverage for Adults* in the *Covered Services* section for more information. The list of covered wellness/preventive services can be found at http://knowyourbenefits.dfa.state.ms.us.

HealthQuotient℠

WebMD Health Services is the Plan's wellness and health promotion services vendor. Through WebMD, participants can complete a HealthQuotient℠ (HQ) health risk assessment and receive a personalized wellness plan and access to online lifestyle improvement programs. These services are provided at no additional charge to the participant. The HQ can be found at www.webmdhealth.com/mississippi or may be accessed through a link on the Plan's website at http://knowyourbenefits.dfa.state.ms.us.

Weight Management Program
ActiveHealth Services provides a telephonic/online weight management program for participants with a Body Mass Index (BMI) of 40 or greater. For more information on this program, see *Weight Management Services* in the *Covered Services* and *Medical Management and Utilization Review* sections.

Tobacco Cessation
Benefits are provided at 100% of the allowable charge for tobacco cessation prescription and over-the counter drugs. See *Tobacco Cessation* in the *Prescription Drug Program* section for more information.

Out-of-Area Participants
An out-of-area participant is a participant whose principal/primary residence is located outside the State of Mississippi. The enrollee's address on file with BCBSMS will determine whether the enrollee and their covered dependents are out-of-area participants. Any covered dependent of an enrollee whose principal/primary residence is located outside the geographic boundaries of the State of Mississippi is an out-of-area participant. The Plan reserves the right to require proof of residence for any participant. For information on coverage levels for out-of-area participants, refer to the *Summary of Base Coverage* or the *Summary of Select Coverage*.

Dependents Age 19 to 26
Covered medical expenses for dependents between the ages of 19 and 26 are paid at the higher in-network level.

Emergency Care
Emergency care received from a non-participating provider may, under certain circumstances, be paid at the in-network benefit level. However, the participant is still responsible for amounts charged by the non-participating provider that exceed the allowable charge.

If a claim for emergency care is processed at the out-of-network benefit level, the participant may appeal the percentage paid on the claim for emergency services by making a written appeal to BCBSMS.

Travel Outside the United States
Benefits are provided for covered services rendered outside the United States. Any claim for such services must be translated to English and converted to U.S. dollars prior to submission.

Out-of-Network Review Services
If a Plan participant needs any medical services that are not available from participating providers, he should call ActiveHealth and request a review of the availability of the needed services. This is called an "out-of-network review" and must be requested **prior to** receiving

medical services. If ActiveHealth certifies that the service is not available in the Network, then that service is covered at the in-network benefit level, even if provided by a non-participating provider. Services approved through an out-of-network review are subject to the appropriate in-network calendar year deductible and coinsurance. Although approval to use a non-participating provider may be granted, the participant is responsible for amounts charged by the provider that exceed the Plan's allowable charge.

Out-of-network review requests will not be approved for follow-up testing after active treatment is complete.

Out-of-network approval does not guarantee that services are covered. Benefits are subject to the patient's eligibility at the time charges are actually incurred, and to all other terms, conditions, and exclusions of the Plan.

Only services that have a 60% coverage level are eligible for an out-of-network review. Out-of-area participants are not eligible to request an out-of-network review.

Identification Cards
For protection from identity theft, the enrollee's Social Security number is not on his medical insurance or prescription drug identification card. The medical insurance identification card includes important information and should be presented when receiving medical services or supplies. The prescription drug identification card should be presented when purchasing prescription drugs. These identification cards provide important addresses and phone numbers.

Plan Maximums
The Plan does not include a lifetime maximum amount. Services subject to a maximum benefit are listed in the *Covered Services* and *Prescription Drug Program* sections.

Integration of Benefits
The Plan includes integration of benefits for Plan maximums between in-network and out-of-network benefits. This means that annual maximums and maximums which apply per day or visit will be cross applied, regardless of whether the provider is participating or non-participating. Coverage maximums will also be cross-applied between all coverage types.

Base Coverage

Base Coverage meets the federal government's criteria of a qualifying high deductible health plan under Section 1201 of the *Medicare Prescription Drug Improvement and Modernization Act of 2003* in regard to establishing a Health Savings Account (HSA). HSAs are portable, interest-bearing, funded accounts to provide for tax-free savings for medical expenses. HSAs allow individuals to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis. The Plan does not administer HSA accounts.

The benefit design for Base Coverage is structured to comply with IRS regulations related to qualified high deductible health plans. There are two types of coverage: Individual Coverage and Family Coverage.

INDIVIDUAL COVERAGE

Deductible and Coinsurance/Co-payment Maximum – Individual Coverage

	In-Network	Out-of-Network
Calendar Year Deductible	$1,800	
Coinsurance/Co-payment Maximum	$2,500	$4,000

Calendar Year Deductible – Individual Coverage

The calendar year deductible is the amount of covered expense a participant must pay each year before the Plan begins to pay its share of covered expenses. All covered expenses, medical and prescription drug, apply toward the calendar year deductible. Once the calendar year deductible has been met, the Plan pays its portion of the allowable charge for covered expenses, and the participant pays prescription drug co-payments for covered prescription drugs and a percentage of the allowable charge for covered medical expenses.

Coinsurance/Co-payment Maximum – Individual Coverage

The coinsurance/co-payment maximum is the maximum amount that an enrollee with individual coverage has to pay in coinsurance and co-payments for covered expenses in a calendar year before benefits will be paid at 100% of the allowable charge. The coinsurance/co-payment maximum provides participants protection against catastrophic healthcare expenses. The amount paid toward meeting the calendar year deductible does not count toward satisfying the coinsurance/co-payment maximum.

The initial $2,500 of coinsurance/co-payments is applied to both the in and out-of-network coinsurance/co-payment maximum. After the initial $2,500 has been met, only the coinsurance amount for services rendered by non-participating providers will be applied to the additional $1,500 out-of-network coinsurance. Once the annual coinsurance/co-payment maximum is met, the Plan pays 100% of the allowable charge for covered medical expenses and prescription drugs for the remainder of that calendar year, except as otherwise specified.

The Plan will never pay 100% of those expenses that do not apply toward satisfying the coinsurance/co-payment maximum.

FAMILY COVERAGE

Deductible and Coinsurance/Co-payment Maximum - Family Coverage

	In-Network	Out-of-Network
Calendar Year Deductible	$3,000	
Coinsurance/Co-payment Maximum	$5,000	$8,000

Calendar Year Deductible – Family Coverage

Family coverage is when an enrollee has one or more covered dependents. If an enrollee has family coverage, there is no separate deductible for each covered individual in the family. All covered expenses, medical and prescription drug, apply toward the family calendar year deductible. Benefits will not be paid until the family deductible for all participants under that ID number has been satisfied. The family deductible also applies when both husband and wife are covered separately as enrollees, one of the enrollees has dependent coverage, and both are enrolled in Base Coverage.

If both husband and wife are covered employees, one carries dependent coverage, and only one of them elects Base Coverage, calendar year deductibles and coinsurance/co-payment amounts are not shared.

If both husband and wife are covered employees with employee only coverage, and both elect Base Coverage, the calendar year deductible and coinsurance/co-payment amounts are not shared.

The following expenses do not count towards the calendar year deductible for Individual or Family Base Coverage:

- Expenses in excess of the allowable charge
- Utilization review penalties
- Expenses in excess of Plan maximum limits
- Services not covered by the Plan including all those found in the *Medical Limitations and Exclusions* section
- Services not considered medically necessary

Coinsurance/Co-payment Maximum – Family Coverage

The coinsurance/co-payment maximum is the maximum amount that an enrollee with family coverage has to pay in coinsurance and co-payments for covered expenses in a calendar year before benefits will be paid at 100% of the allowable charge. If an enrollee has family coverage, there is no separate coinsurance/co-payment maximum for each individual. The family coinsurance/co-payment maximum also applies when both husband and wife are covered

separately as enrollees, one of the enrollees has family coverage, and both are enrolled in Base Coverage. The amount paid toward meeting the calendar year deductible does not count toward satisfying the coinsurance/co-payment maximum.

The initial $5,000 of coinsurance and co-payments is applied to both the in and out-of-network coinsurance/co-payment maximum. After the initial $5,000 has been applied, only the coinsurance amount for services rendered by non-participating providers will be applied to the additional $3,000 out-of-network coinsurance/co-payment maximum. Once the annual coinsurance/co-payment maximum is met, the Plan pays 100% of the allowable charge for covered medical expenses and prescription drugs for the remainder of that calendar year, except as otherwise specified.

The Plan will never pay 100% for those expenses that do not apply toward satisfying the coinsurance/co-payment maximum.

Coinsurance

Once a participant has met the calendar year deductible, the Plan pays a portion of the allowable charge for covered medical expense. The participant pays the remainder in the form of coinsurance.

Any fees charged by a non-participating provider that are above the allowable charge are not part of the coinsurance amount. The Plan will not pay any portion of these charges.

Helpful Tip: Participating providers agree not to charge any amount above the Plan's allowable charge for covered services.

Do These Expenses Count Towards The Coinsurance/Co-Payment Maximum?	
YES	**NO**
▪ The coinsurance paid for hospital inpatient services ▪ The coinsurance paid for other covered expenses ▪ The private room co-payment ▪ The emergency room co-payment ▪ Prescription drug co-payments	▪ The calendar year deductible ▪ Expenses in excess of the allowable charge ▪ Expenses in excess of Plan maximum limits ▪ Utilization review penalties ▪ Services not covered by the Plan including all those found in the *Medical Limitations and Exclusions* section ▪ Generic drug differential amounts ▪ Services not considered medically necessary

Summary of Base Coverage Medical Benefits

This is only a summary of the medical benefits under the Base Coverage. It does not provide all details and provisions of the Plan. Some limitations and exclusions apply and can be found within the *Plan Document*.

	In-Area Participants		**Out-of-Area Participants**	
	In-Network	***Out-of-Network***	***In-Network***	***Out-of-Network***
Calendar Year Deductible – Individual Coverage	**$1,800**		**$1,800**	
Calendar Year Deductible – Family Coverage	**$3,000**		**$3,000**	
Coinsurance Maximum – Individual Coverage	**$2,500**	**$4,000**	**$2,500**	**$4,000**
Coinsurance Maximum – Family Coverage	**$5,000**	**$8,000**	**$5,000**	**$8,000**
All benefits are subject to the deductible unless otherwise noted in the Covered Services section.				
Physician Services	**80%**	**60%**	**80%**	**75%**
Hospital –In-patient*	**80%**	**60%**	**80%**	**75%**
Hospital –Out-patient	**80%**	**60%**	**80%**	**75%**
Emergency Room**	**80%**	**60%**	**80%**	**75%**
X-Rays, Laboratory	**80%**	**60%**	**80%**	**75%**
Adult Wellness/Preventive Services	**100%**	**Not Covered**	**100%**	**100%**
Maternity – Attending Physician	**100%**	**90%**	**100%**	**90%**
Maternity – Hospital*; Other Services	**80%**	**60%**	**80%**	**75%**
Ambulatory Surgical Facility	**80%**	**60%**	**80%**	**75%**
Cardiac Rehabilitation (outpatient)	**80%**	**60%**	**80%**	**75%**
Chiropractic Services	**80%**	**60%**	**80%**	**75%**
Durable Medical Equipment	**80%**	**60%**	**80%**	**75%**
Home Infusion Therapy*	**80%**	**60%**	**80%**	**75%**
Hospice Care Services*	**80%**	**60%**	**80%**	**75%**
Long Term Acute Care Facility*	**80%**	**60%**	**80%**	**75%**
Mental Health:				
Inpatient*	**80%**	**60%**	**80%**	**75%**
Outpatient	**80%**	**60%**	**80%**	**75%**
Day Treatment	**80%**	**60%**	**80%**	**75%**
Partial Hospitalization	**80%**	**60%**	**80%**	**75%**
Residential Treatment*	**80%**	**60%**	**80%**	**75%**
Nurse Practitioner	**80%**	**60%**	**80%**	**75%**
Occupational Therapy	**80%**	**60%**	**80%**	**75%**
Optometric Services	**80%**	**60%**	**80%**	**75%**
Organ Transplants*	**80%**	**60%**	**80%**	**75%**
Physical Therapy	**80%**	**60%**	**80%**	**75%**
Private Duty and Home Health Nursing Services*	**80%**	**60%**	**80%**	**75%**
Skilled Nursing Facility*	**80%**	**60%**	**80%**	**75%**
Sleep Disorders	**80%**	**60%**	**80%**	**75%**
Speech Therapy	**80%**	**60%**	**80%**	**75%**

	In-Area Participants		Out-of-Area Participants	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*
Substance Abuse:				
Inpatient*	**80%**	**60%**	**80%**	**75%**
Outpatient	**80%**	**60%**	**80%**	**75%**
Intensified Outpatient	**80%**	**60%**	**80%**	**75%**
Residential Treatment*	**80%**	**60%**	**80%**	**75%**
Well-Newborn Nursery Care	**100%**	**Not Covered**	**100%**	**75%**
Well-Child Physician Office Visits	**100%**	**Not Covered**	**100%**	**100%**
Well-Child Specified Routine Tests	**100%**	**Not Covered**	**100%**	**100%**
Well-Child Routine Immunization	**100%**	**Not Covered**	**100%**	**100%**

Services must be certified as medically necessary by ActiveHealth to be covered by the Plan.
****See *Emergency Care on page 4.***

Additional Benefits

*Coverage for the services listed below is subject to the calendar year deductible of $1,800 individual/$3,000 family and the **in-network** coinsurance maximum of $2,500 individual/ $5,000 family. These services are not eligible for an out-of-network review.*

Benefit	**In-Area Participants**		**Out-of-Area Participants**	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*
Accidental Injury to Natural Teeth	**80%**	**75%**	**80%**	**75%**
Anesthesia	**80%**	**75%**	**80%**	**75%**
Podiatry Services	**80%**	**75%**	**80%**	**75%**
Ambulance*	**80%**	**75%**	**80%**	**75%**
Medical Supplies	**80%**	**75%**	**80%**	**75%**
Prosthetic and Orthotic Procedures and Devices	**80%**	**75%**	**80%**	**75%**
TMJ	**80%**	**75%**	**80%**	**75%**

See Emergency Care on page 4.

Select Coverage

Deductibles and Coinsurance Maximums for Medical Services

	IN-NETWORK	OUT-OF-NETWORK
Individual Calendar Year Medical Deductible	$1,000	$2,000
Family Calendar Year Medical Deductible	$2,000	$4,000
Individual Medical Coinsurance Maximum	$2,500	$3,500
Individual Prescription Drug Deductible	$75	

Individual Calendar Year Medical Deductible

The calendar year medical deductible is the amount of covered medical expense a participant must pay each year before the Plan begins to pay its share of covered medical expenses. Once the calendar year deductible is met, the Plan pays a percentage of the allowable charge for covered medical expenses.

The initial $1,000 of covered medical expense will apply to both the in and out-of-network deductible. After the initial $1,000 has been applied, only services rendered by a non-participating provider will be applied to the additional $1,000 out-of-network deductible.

The following expenses do not count towards the calendar year medical deductible:

- Prescription drug deductible
- Expenses in excess of the allowable charge
- Expenses in excess of Plan maximum limits
- Services not considered medically necessary
- Emergency room co-payment
- Prescription drug co-payments
- Utilization review penalties
- Private room co-payment
- Services not covered by the Plan

Family Calendar Year Medical Deductible

Once a family has paid the family medical deductible in a calendar year, all covered participants in that family will have satisfied their individual medical deductibles for that calendar year. The family medical deductible also applies when both husband and wife are covered separately as enrollees and both are enrolled in Select Coverage. No individual family member may contribute more than $1,000 to the in-network family medical deductible or more than $2,000 to the out-of-network family medical deductible.

The initial $2,000 of covered expense will apply to both the in and out-of-network family medical deductible. After the initial $2,000 has been applied, only services rendered by a non-participating provider will be applied to the additional $2,000 out-of-network family medical deductible.

Coinsurance
Once a participant has met the calendar year medical deductible, the Plan pays a portion of the allowable charge for covered medical expenses. The participant pays the remainder in the form of coinsurance.

Any fees charged by a non-participating provider that are above the allowable charge are not part of the coinsurance amount. The Plan will not pay any portion of these charges.

Helpful Tip: Participating providers agree not to charge any amount above the Plan's allowable charge for covered services.

Individual Medical Coinsurance Maximum
The medical coinsurance maximum is the maximum amount that each participant has to pay in coinsurance for covered medical expenses in a calendar year before benefits will be paid at 100%. The medical coinsurance maximum protects a participant from having to pay catastrophic medical bills in a given year. The amount paid toward meeting the calendar year individual and family medical deductibles does not count toward satisfying the medical coinsurance maximum.

The initial $2,500 of medical coinsurance is applied to both the in and out-of-network medical coinsurance maximum. After the initial $2,500 has been met, only the coinsurance amount for services rendered by non-participating providers will be applied to the additional $1,000 out-of-network coinsurance. Once the annual medical coinsurance maximum is met, the Plan covers 100% of the allowable charge for covered medical expenses for the remainder of that calendar year, except as otherwise specified. Each individual participant must meet their medical coinsurance maximum before benefits are paid at 100%; there is no family medical coinsurance maximum. The Plan will never pay 100% for those expenses that do not apply toward satisfying the coinsurance maximum.

Do These Expenses Count Towards The Coinsurance Maximum?	
YES	**NO**
▪ The coinsurance paid for hospital inpatient services ▪ The coinsurance paid for other covered medical expenses	▪ The calendar year deductibles ▪ The family deductibles ▪ The prescription drug deductible ▪ Expenses in excess of the allowable charge ▪ Expenses in excess of Plan maximum limits ▪ Utilization review penalties ▪ Services not covered by the Plan including all those found in the *Medical Limitations and Exclusions* section ▪ Prescription drug co-payments ▪ Generic drug differential amounts ▪ Services not considered medically necessary

Do These Expenses Count Towards The Coinsurance Maximum?	
YES	**NO**
	▪ The private room co-payment ▪ The emergency room co-payment

Individual Prescription Drug Deductible
Before the Plan will pay any of the cost for prescription drugs, each participant must first satisfy a $75 prescription drug deductible each calendar year.

The prescription drug deductible and co-payment amounts will not apply toward satisfying the medical calendar year deductible or coinsurance maximum.

Summary of Select Coverage Medical Benefits

This is only a summary of the medical benefits under Select Coverage. It does not provide all details and provisions of the Plan. Some limitations and exclusions apply and can be found within this *Plan Document*.

	In-Area Participants		**Out-of-Area Participants**	
	In-Network	***Out-of-Network***	***In-Network***	***Out-of-Network***
Individual Calendar Year Medical Deductible	**$1,000**	**$2,000**	**$1,000**	**$2,000**
Family Calendar Year Medical Deductible	**$2,000**	**$4,000**	**$2,000**	**$4,000**
Individual Medical Coinsurance Maximum	**$2,500**	**$3,500**	**$2,500**	**$3,500**
All benefits are subject to the medical deductibles unless otherwise noted in the Covered Services section.				
Physician Services	**80%**	**60%**	**80%**	**75%**
Hospital – In-patient*	**80%**	**60%**	**80%**	**75%**
Hospital – Out-patient	**80%**	**60%**	**80%**	**75%**
Emergency Room**	**80%**	**60%**	**80%**	**75%**
X-Rays, Laboratory	**80%**	**60%**	**80%**	**75%**
Adult Wellness/Preventive Services	**100%**	**Not Covered**	**100%**	**100%**
Maternity – Attending Physician	**100%**	**90%**	**100%**	**90%**
Maternity – Hospital*; Other Services	**80%**	**60%**	**80%**	**75%**
Ambulatory Surgical Facility	**80%**	**60%**	**80%**	**75%**
Cardiac Rehabilitation (outpatient)	**80%**	**60%**	**80%**	**75%**
Chiropractic Services	**80%**	**60%**	**80%**	**75%**
Durable Medical Equipment	**80%**	**60%**	**80%**	**75%**
Home Infusion Therapy*	**80%**	**60%**	**80%**	**75%**
Hospice Care Services*	**80%**	**60%**	**80%**	**75%**
Long Term Acute Care Facility*	**80%**	**60%**	**80%**	**75%**
Mental Health:				
Inpatient*	**80%**	**60%**	**80%**	**75%**
Outpatient	**80%**	**60%**	**80%**	**75%**
Day Treatment	**80%**	**60%**	**80%**	**75%**
Partial Hospitalization	**80%**	**60%**	**80%**	**75%**
Residential Treatment*	**80%**	**60%**	**80%**	**75%**
Nurse Practitioner	**80%**	**60%**	**80%**	**75%**
Occupational Therapy	**80%**	**60%**	**80%**	**75%**
Optometric Services	**80%**	**60%**	**80%**	**75%**
Organ Transplants*	**80%**	**60%**	**80%**	**75%**
Physical Therapy	**80%**	**60%**	**80%**	**75%**
Private Duty and Home Health Nursing Services*	**80%**	**60%**	**80%**	**75%**
Skilled Nursing Facility*	**80%**	**60%**	**80%**	**75%**
Sleep Disorders	**80%**	**60%**	**80%**	**75%**
Speech Therapy	**80%**	**60%**	**80%**	**75%**

	In-Area Participants		Out-of-Area Participants	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*
Substance Abuse:				
Inpatient*	**80%**	**60%**	**80%**	**75%**
Outpatient	**80%**	**60%**	**80%**	**75%**
Intensified Outpatient	**80%**	**60%**	**80%**	**75%**
Residential Treatment*	**80%**	**60%**	**80%**	**75%**
Well-Newborn Nursery Care	**100%**	**Not Covered**	**100%**	**75%**
Well-Child Physician Office Visits	**100%**	**Not Covered**	**100%**	**100%**
Well-Child Specified Routine Tests	**100%**	**Not Covered**	**100%**	**100%**
Well-Child Routine Immunization	**100%**	**Not Covered**	**100%**	**100%**

Services must be certified as medically necessary by ActiveHealth to be covered by the Plan.
****See Emergency Care on page 4.***

Additional Benefits

Coverage for the services listed below is subject to the in-network calendar year medical deductibles and the individual medical coinsurance maximum of $2,500. These services are not eligible for an out-of-network review.

Benefit	In-Area Participants		Out-of-Area Participants	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*
Accidental Injury to Natural Teeth	**80%**	**75%**	**80%**	**75%**
Anesthesia	**80%**	**75%**	**80%**	**75%**
Podiatry Services	**80%**	**75%**	**80%**	**75%**
Ambulance*	**80%**	**75%**	**80%**	**75%**
Medical Supplies	**80%**	**75%**	**80%**	**75%**
Prosthetic and Orthotic Procedures and Devices	**80%**	**75%**	**80%**	**75%**
TMJ	**80%**	**75%**	**80%**	**75%**

See Emergency Care on page 4.

Health Insurance Eligibility and Enrollment

Enrollee Eligibility
The following persons are eligible for coverage:

- **A full-time employee who:**
  - receives compensation directly from one of the following Mississippi public entities:
    - ◊ department, agency, or institution of State Government,
    - ◊ public school district,
    - ◊ community /junior college,
    - ◊ institution of higher learning, or
    - ◊ public library
  - works for the State's judicial branch,
  - works for the State's legislative branch,
  - works as a full-time salaried Judge,
  - works as a full-time salaried District Attorney, or is a member of his staff,
  - works as a full-time compulsory school attendance officer, or
  - works for a university based program authorized under state law for deaf, aphasic, and emotionally disturbed children.

- **A regular non-student school bus driver.**

- **A COBRA participant.**

- **A retired employee.**

- **A surviving spouse.**

An employee making contributions to a retirement plan approved by the Mississippi Public Employees' Retirement System (PERS) is considered a full-time employee.

NOTE: Any employee participating in the Plan who continues coverage as a retiree and receives retirement benefits from PERS must be covered as a retiree and not as an active employee. This does not include retirees from the Mississippi Highway Safety Patrol Retirement System.

Dependent Eligibility
Eligible dependents include the following:

- The enrollee's legal spouse as defined by Mississippi law, unless the spouse is also an eligible employee under the Plan.

- The enrollee's child up to age 26. When a child reaches the age of 26, he is terminated from the Plan.

- The term "child" includes the following:
  - Natural child
  - Stepchild
  - Legally adopted child
  - Child placed in the enrollee's home in anticipation of adoption
  - Child for whom the enrollee is legal guardian
  - Child for whom the enrollee has legal custody
  - Child of the enrollee who is required to be covered by reason of a Qualified Medical Child Support Order

The enrollee's unmarried dependent child is eligible for coverage at any age provided the dependent is permanently mentally or physically disabled, so incapacitated as to be incapable of self-sustaining employment, and dependent upon the enrollee for 50% or more support. The disabling condition must have occurred prior to the dependent's 26th birthday. The enrollee must provide written proof of the incapacity (including documentation from a physician). Neither a reduction in work capacity nor an inability to find employment is, of itself, evidence of incapacitation. Coverage may continue for as long as the incapacitation exists and the enrollee remains covered under the Plan.

Proof of disability must be provided to BCBSMS 31 days prior to the date a child would cease to be covered because of age. The Plan reserves the right to request proof of continuous disability.

Initial Enrollment for New Employees

Initial enrollment applies to newly eligible active employees. An employee is required to complete an *Application for Coverage* form to apply for or waive coverage within the first 31 days of employment. The employee's Social Security number must be provided on the *Application for Coverage* form in order for an employee to enroll in the Plan. Dependent information on the *Application for Coverage* form must include birth date, Social Security Number, and mailing address, if different from the enrollee.

An employee who was initially employed before January 1, 2006, is a Legacy Employee. An employee employed on or after January 1, 2006, who was ever a full-time employee of a community/junior college, public library, public school district, State agency or university prior to January 1, 2006, is a Legacy Employee. An employee initially employed on or after January 1, 2006, is a Horizon Employee.

An employee may choose Base Coverage or Select Coverage at initial enrollment. If timely application is made and appropriate premiums are paid, the effective date of coverage for the employee and any eligible dependent(s) will be the first day of employment. If an employee does not enroll or if he waives coverage within 31 days of employment, application may be made only during an open enrollment or special enrollment period. Enrollment periods are discussed later in this section.

All new employees and their dependents between the ages of 19 and 26 applying for coverage are subject to a twelve (12) month pre-existing condition exclusion period. If the enrollee and/or

dependents had other health care coverage defined as "creditable coverage" under the Health Insurance Portability and Accountability Act (HIPAA), and that other coverage terminated within 63 days of the effective date with this Plan, the prior health coverage will be credited against the 12-month pre-existing condition exclusion under the Plan. In order to reduce the pre-existing condition exclusion period, the employee must provide proof of prior creditable coverage.

Disabled Dependent

New employees who wish to enroll a permanently disabled dependent must submit a *Request for Coverage for a Mentally or Physically Disabled Dependent* form along with the *Application for Coverage* form. This form can be obtained from BCBSMS. BCBSMS will make final determination of disability. The disabling condition must have occurred prior to the dependent's 26th birthday.

Right to Request Documentation

If requested, documentation of dependent relationship, such as marriage license or birth certificate, must be provided. To enroll a child due to adoption, placement in anticipation of adoption, legal guardianship, or legal custody, a copy of the applicable court order must be submitted with the *Application for Coverage* form.

Paying for Coverage

The State pays the cost of Base Coverage for all active Employees. Employees may enroll in Select Coverage and pay a portion of the premium. The cost for dependent coverage is the employee's responsibility under both coverage types. Premiums for the cost of Select Coverage and dependent coverage for active employees are paid through payroll deductions. Premium rates can be found at http://knowyourbenefits.dfa.state.ms.us.

Special Rules for When Family Members are Employees

If both husband and wife are eligible employees, they may be covered by the Plan as employees but not as a dependent of their spouse. In addition, if a dependent child is an active employee, he may be covered by the Plan as an employee but not as a dependent of his parent. Dependent children may be covered as dependents of only one of the parents/stepparents. At no time may a dependent be covered under more than one contract under this Plan. An employee must indicate on the *Application for Coverage* form if his spouse is also an active employee.

If one spouse terminates employment, he may be added as a dependent under the remaining employee's coverage. In order for the terminated spouse to be added as a dependent, the remaining employee must complete an *Application for Coverage* form within 60 days of their spouse losing coverage under the Plan.

Plan Enrollment Periods

The following Plan enrollment periods do not apply to retirees and surviving spouses. Enrollment periods for retirees and surviving spouses can be found in the *Retiree Eligibility and Medical Coverage* section.

Open Enrollment for Active Employees

Each October during the annual open enrollment period, an employee may choose to elect coverage for himself or his eligible dependents. The coverage elected during open enrollment takes effect on January 1st of the following calendar year. Coverage elected during an open enrollment period is subject to an 18-month pre-existing condition exclusion period, except for dependent children under age 19. A participant will receive credit for prior creditable coverage that occurred without a break in coverage of 63 days or more. An employee may choose either Base Coverage or Select Coverage during open enrollment.

Open Enrollment for COBRA Participants

Each October during the annual open enrollment period, a COBRA participant may choose to elect coverage for his eligible dependent(s). The coverage elected during open enrollment takes effect on January 1st of the following calendar year. Coverage elected during an open enrollment period is subject to an 18-month pre-existing condition exclusion period, except for dependent children under age 19. A participant will receive credit for prior creditable coverage that occurred without a break in coverage of 63 days or more. A COBRA participant may choose either Base Coverage or Select Coverage during open enrollment.

Special Enrollment Periods resulting from loss of coverage

An employee, dependent of a covered employee, or dependent of a COBRA participant who loses coverage under another health plan will be eligible to enroll for coverage in the Plan if the following apply:

- The employee declined coverage for himself or his dependents when first eligible because the employee or dependent was covered by other health insurance coverage; or the COBRA participant declined coverage for his dependent when first eligible because the dependent was covered by other health insurance coverage; and
- The employee or dependent lost other coverage as a result of any of the following qualifying events:
    - Divorce.
    - The employee or dependent is no longer eligible for coverage. (Loss of coverage due to non-payment of premiums does not qualify.)
    - The employer ceased to contribute toward the cost of the other health plan, and it was terminated.
    - The employee or dependent's COBRA continuation has run out.

To enroll for coverage under these circumstances, an *Application for Coverage* form must be submitted within 60 days of losing coverage under the other plan and appropriate premium

payments must be made. As part of the application process, proof of loss of coverage must be provided. If these requirements are met, coverage under the Plan will take effect the first day following the loss of other coverage. The *Application for Coverage* form must be submitted within 60 days of the loss of other coverage even if the Certificate of Creditable Coverage has not been received. The Certificate of Creditable Coverage must be provided when received from the previous health insurance provider.

Employees enrolling or dependents between the ages of 19 and 26 added during a special enrollment period are subject to a 12-month pre-existing condition exclusion period. A participant will receive credit for prior creditable coverage that occurred without a break in coverage of 63 days or more.

An enrollee adding coverage due to a special enrollment event may change coverage types (Base to Select, or Select to Base). There is no deductible or out-of-pocket credit if an enrollee changes coverage types during a calendar year.

Special Enrollment Period as a result of gaining a new dependent

An enrollee may enroll a new dependent for coverage if the new dependent was acquired as a result of any of the following qualifying events:

- Marriage,
- Birth,
- Adoption, or placement in anticipation of adoption,
- Legal custody,
- Legal guardianship, or
- Qualified Medical Child Support Order (QMCSO).

If an active employee is not covered by the Plan at the time of this qualifying event, he may enroll himself and any other eligible dependent(s).

To enroll for coverage under these circumstances, an *Application for Coverage* form must be submitted within 60 days of the event, and appropriate premium payments must be made. As part of the application process, the enrollee may be required to provide proof of the qualifying event. If these requirements are met, coverage under the Plan will take effect as of the date of the qualifying event. (In the case of a QMCSO, the coverage will be effective the 1st day of the month following the date of the order.) A copy of the procedures regarding QMCSOs can be obtained by contacting the Department of Finance and Administration, Office of Insurance.

Employees enrolling or dependents between the ages of 19 and 26 added during a special enrollment period are subject to a 12-month pre-existing condition exclusion period. A participant will receive credit for prior creditable coverage that occurred without a break in coverage of 63 days or more.

An enrollee adding coverage due to a special enrollment event may change coverage types (Base to Select, or Select to Base). There is no deductible or out-of-pocket credit if an enrollee changes coverage types during a calendar year.

If an enrollee is applying for coverage for a newborn, the *Application for Coverage* form must be submitted within 60 days of the child's date of birth even if a Social Security number for the newborn is not available at the time. The Social Security number can be provided when received from the Social Security Administration.

IMPORTANT NOTE
If the enrollee does not apply for coverage for himself or his eligible dependents during any of the special enrollment periods described herein, application cannot be made until an open enrollment period.

Creditable Coverage
Creditable coverage is health care coverage as defined under the Health Insurance Portability and Accountability Act (HIPAA). Creditable coverage includes comprehensive medical coverage under group health plans, individual health insurance, Medicare Part A, state health benefit risk pools, and public health plans such as Medicaid or the Children's Health Insurance Program. A participant will receive credit for prior creditable coverage that occurred without a break in coverage of 63 days or more. Any coverage occurring prior to a break in coverage of 63 days or more will not be credited against a pre-existing condition exclusion period.

Transferring Within the Plan
If an employee transfers between employer units, begins full-time employment with the new employer unit at any time during the following month, and completes an *Application for Coverage* form within 31 days of his date of employment, there will be no break in coverage.

The employee may choose Base Coverage or Select Coverage at this time. There is no deductible or out-of-pocket credit if an employee changes coverage types when transferring to a new employer unit during the year. The employee may also add eligible dependents at this time. The employee must complete an *Application for Coverage* form with the new employer unit within 31 days of his date of employment.

Coverage During the Summer Months for Employees of a School District, Community/Junior College, or University

- **A covered school employee** who is off for summer recess is entitled to continuous insurance coverage during the summer months.

- **A covered school employee** who leaves one employer unit at the end of the school year, does not work for an employer unit during the summer months, and becomes employed by another employer unit when the school calendar resumes in the fall, will remain covered by the old employer unit until July 31st. Coverage with the new employer unit will begin August 1st.

- **A covered school employee** who leaves one employer unit at the end of the school year, and becomes employed by another employer unit during the summer months will remain covered by the old employer unit until the end of the month in which the employee transfers. Coverage under the new employer unit will be effective on the first of the month following the transfer.

Address Changes

An enrollee's address must be kept up to date to ensure that he receives all communications regarding life and health insurance coverage. Active employee's address changes must be submitted to the employee's employer unit. Retirees, surviving spouses, and COBRA participants must contact BCBSMS to make an address change.

When Coverage Ends

An active employee's coverage under the Plan ends at the end of the month in which he terminates from full-time employment. Coverage will also end if any required contributions are not paid, or if the Plan is terminated for some reason. Dependent coverage ends at the same time or at the end of the month in which the Plan is made aware that a dependent is no longer eligible. Coverage ends at the end of the month in which the employee or dependent loses eligibility or contributions cease.

Termination of coverage ends all rights of the participant to benefits under the Plan as of the effective date of coverage termination.

If a school employee terminates employment at the end of a school year, coverage end date is dependent on receipt of the employee's final check. If the final check is received on June 30, coverage will end June 30th. If the final check is received on July 31, coverage ends July 31st.

If a school employee terminates employment at the end of the school year, but returns to work (with either the same or new district or college) no later than September 1st of the following school year, coverage in the Plan will be reinstated. Reimbursement will be made for any COBRA premiums paid.

If a school employee does not terminate employment at the end of the school year but does not return to work for the fall semester, coverage will terminate at the end of the month in which the school begins fall semester.

Terminating Dependent Coverage

To terminate coverage for a dependent, an enrollee must complete an *Application for Coverage* form, except when termination occurs as a result of employee's termination of employment. Coverage will be terminated at the end of the month in which the *Application for Coverage* is received. Retroactive terminations are not allowed. Termination of coverage ends all rights of the participant to benefits under the Plan as of the date coverage ends.

Covered Services

Benefits are provided for the services listed in this section. All benefits are subject to the calendar year deductibles and the allowable charges, unless otherwise noted. Participants in Base Coverage or Select Coverage should refer to the Summaries of Benefits for coinsurance amounts. Benefits are provided for covered expenses incurred by a participant as a result of a non-occupational injury or non-occupational illness, only as expressly provided in this Plan.

Ambulance

Medically necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

From the place where the participant is injured or stricken by illness to the nearest appropriate facility where treatment is to be given when deemed medically necessary;

From a hospital where the participant is an inpatient to another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the hospital of origin and back to the hospital of origin after such services have been rendered, or;

From a hospital to another hospital when the discharging hospital has inadequate treatment facilities.

Ambulatory Surgical Facility

Ambulatory surgical facility services are:

- Pre-operative laboratory procedures directly related to a surgical procedure.
- Pre-operative preparation.
- Use of facility (operating rooms, recovery rooms, and surgical equipment).
- Anesthesia, drugs, and surgical supplies.

Cardiac Rehabilitation - Outpatient

Benefits for outpatient cardiac rehabilitation are provided for patients with a clear medical need, and referred by the attending physician. Prior approval must be obtained from BCBSMS. The attending physician must submit a formal treatment plan to BCBSMS (including number of visits, duration of therapy, and expected outcomes). Maintenance or exercise therapy is not covered.

Participants must use a cardiac rehabilitation program that is certified by the American Association of Cardiovascular and Pulmonary Rehabilitation. Participants can contact BCBSMS to locate a certified provider.

Chiropractic Services
Chiropractic services are limited to a maximum of $2,000 per participant during a calendar year. Only manipulative therapy services apply to the $2,000 maximum. Payments for x-rays or laboratory services are not applied toward this maximum.

Dental Services
Dental services are not covered under the Plan except for the following:

Coverage is provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) caused solely through external means. The accidental injury must have occurred while the participant is covered under the Plan or as a direct result of a disease covered by the Plan. Injury to teeth as a result of chewing or biting is not considered an accidental injury.

Coverage is provided for inpatient hospital services/supplies and associated anesthesia services for dental care and treatment and dental or oral surgery if the hospital stay is determined to be medically necessary by ActiveHealth.

Coverage is provided for outpatient hospital or ambulatory surgical facility services/supplies and associated anesthesia services for dental care if it is determined to be medically necessary by BCBSMS.

Except as indicated above, benefits are not provided for dental services including, but not limited to, the following:

- In-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services, whether or not the purpose of such services or supplies is to relieve pain
- Extraction of wisdom teeth
- Removal, repair, replacement, restoration, or reposition of teeth lost or damaged in the course of biting or chewing
- Repair, replacement, or restoration of fillings, crowns, dentures, or bridgework
- Periodontal treatment (i.e., gum disease)
- Dental cleaning, in-mouth scaling, planning, or scraping
- Myofunctional therapy (muscle training therapy or training to correct or control harmful habits)
- Root canal therapy
- Routine tooth removal
- Any dental service or treatment not associated with an accidental injury or as a direct result of a disease covered by the Plan
- TMJ, except to the extent coverage is specifically provided in this *Plan Document*

Diagnostic Services - X-rays and Laboratory Services
Medically necessary diagnostic services, such as x-rays and laboratory examinations, are covered. For diagnostic services during routine examinations, see *Wellness/Preventive Coverage*. Refer to the *Medical Management and Utilization Review* section for certification requirements for specified outpatient diagnostic tests.

Outpatient diagnostic tests requiring certification through ActiveHealth (unless performed in an emergency room setting): ● CAT Scan ● MRI Scan

Durable Medical Equipment
Durable medical equipment (DME) must be prescribed by the attending physician and determined by BCBSMS to be medically necessary for treatment of the illness or injury or to prevent the participant's further deterioration. Prior approval by BCBSMS is recommended. DME is an item that must be (1) made to withstand repeated use; (2) primarily used to serve a medical purpose rather than for comfort or convenience; (3) generally not useful to a person in the absence of illness, injury, or disease; and (4) appropriate for use in the participant's home.

Benefits for DME are based on the allowable charge for basic equipment. Benefits for any deluxe item will be limited to the allowable charge for the basic version of the item. If special features are medically necessary to maintain or promote patient mobility or function, BCBSMS may approve those features. DME may be rented or purchased, based on the determination of BCBSMS. Rental fees cannot exceed the cost of buying the item. A DME claim must include a letter explaining medical necessity from the physician.

Emergency Room Services
Benefits are provided for treatment in a hospital emergency room. A $100 emergency room co-payment per visit will apply after the first emergency room visit in any calendar year. The emergency room co-payment is in addition to the deductible and coinsurance amount. The emergency room co-payment will not be charged after a participant in Base Coverage has met the coinsurance/co-payment maximum.

Emergency care received from a non-participating provider may, under certain circumstances, be paid at the in-network benefit level. However, the participant is still responsible for amounts charged by the non-participating provider that exceed the allowable charge.

If a claim for emergency care is processed at the out-of-network benefit level, the participant may appeal the percentage paid on the claim for emergency services by making a written appeal to BCBSMS.

Home Infusion Therapy
Benefits are provided for home infusion therapy services approved by ActiveHealth for treatment in the patient's home. ActiveHealth must certify services as medically necessary prior to beginning the therapy.

Covered expenses for Home Infusion Therapy are limited to the following:

▪ Prescription drugs ▪ Intravenous solutions ▪ Durable medical equipment ▪ Pharmacy compounding and dispensing services ▪ Fees associated with drawing blood for the purpose of monitoring response to therapy	▪ Therapist services ▪ Ancillary medical supplies ▪ Nursing visits – including initiation of home infusion therapy, intravenous restarts, and emergency care when medically necessary to provide home infusion therapy

Hospice Care
Benefits are provided for inpatient and home hospice services for up to 6 months, subject to certification of medical necessity by ActiveHealth.

Hospital Services
Covered inpatient and outpatient hospital services and supplies include the following:

- Hospital room and board (including dietary and general nursing services), subject to a $20 per day private room co-payment
- Operating or treatment rooms
- Anesthetics and their administration
- Intravenous injections and solutions
- Physical/ Occupational/ Speech therapy
- Radiation therapy
- Oxygen and its administration
- Diagnostic services
- Intensive, coronary, and Burn Care Unit services
- Drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization, including charges for take-home drugs
- Dressings and supplies
- Blood transfusions, including the cost of whole blood, blood plasma and expanders
- Psychological testing when ordered by the attending physician

All inpatient admissions to a hospital require certification by ActiveHealth. Inpatient rehabilitative services are limited to acute short-term care in a hospital or rehabilitation hospital, as approved by ActiveHealth. Refer to the *Medical Management and Utilization Review* section for certification requirements.

For inpatient hospital services, a $20 per day private room co-payment will apply. The private room co-payment will not be charged after a participant in Base Coverage has met the coinsurance/co-payment maximum

Long Term Acute Care Facility
All admissions to a Long Term Acute Care Facility must be certified as medically necessary by ActiveHealth.

Mastectomy
The following services related to medically necessary mastectomies are covered:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and care of physical complications of mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and patient.

Maternity
Maternity benefits are provided to covered enrollees or covered spouses. Other female dependents are not eligible for maternity benefits. See the *Medical Management and Utilization Review* section for more information.

The attending physician will be reimbursed for covered routine prenatal care and delivery at 100% of the allowable charge (90% for non-participating physician), not subject to the calendar year deductible.

Benefits for the following prenatal laboratory and diagnostic procedures will be provided at 100% of the allowable charge (90% for non-participating physician), not subject to the calendar year deductible:

Prenatal Laboratory and Diagnostic Procedures	Limit Per Pregnancy
Initial Obstetric Screening Panel	1
Ultrasound	2
Urinalysis, screening dip stick	3
Urinalysis, spun	1
Hemoglobin/Hematocrit/CBC	2
Antibody Test for Rh-Negative (if unsensitized)	1
Alpha-fetoprotein	1
Diabetes Screening	1
Cervical Cytology (PAP)	1
Group B Strep	1
HIV	1
Gonorrhea	1
Chlamydia	1
Bacteriuria Screening	1
Hepatitis B Screening	1

Regular Plan benefits will be provided for other prenatal laboratory and diagnostic procedures, inpatient hospital delivery, and other covered services.

Maternity Management Program
As soon as a participant finds out that she is pregnant, she should call ActiveHealth to enroll in the voluntary maternity management program. This program is an education and monitoring service that provides: a personal nurse to assist in the early identification of risk factors, high-risk screening, pregnancy education and support, and ongoing monitoring.

As part of the program, the participant will receive educational materials and access to a special nurse line for any questions that arise during the pregnancy. All services provided in this program are at no cost to the participant.

***Important Note*: Whether or not the participant chooses to participate in the maternity management program, she is still responsible for certifying the hospital admission for delivery.**

Adding a Newborn
In order for a newborn to be covered from date of birth, an *Application for Coverage* form must be completed within 60 days of the date of birth (see *Special Enrollment Periods*) and the appropriate premiums must be paid. **Reporting the baby's birth by phone to ActiveHealth or BCBSMS does not automatically add the baby to the enrollee's coverage**.

Medical Supplies
Medical supplies such as oxygen, crutches, splints, casts, trusses and braces, syringes and needles, catheters, and colostomy bags and supplies are covered, based on medical necessity.

Mental Health Services
Benefits are provided for inpatient, residential treatment facility, day treatment/partial hospitalization, and outpatient mental health services. All inpatient hospital and residential treatment facility admissions for mental health services must be certified as medically necessary by ActiveHealth. Refer to the *Medical Management and Utilization Review* section for certification requirements.

Nursing Services - Private Duty and Home Health
Nursing services of a practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) are covered when those services meet the following criteria:

- Are ordered and supervised by a physician,
- Require the technical skills of an RN or LPN,
- Are certified by ActiveHealth to be provided in the home, and
- Are certified by ActiveHealth as medically necessary prior to initiation.

No nursing benefits will be provided for:

- Services of a nurse who ordinarily lives in the patient's home or is a member of the patient's family
- Services of an aide, orderly, companion, or sitter
- Nursing services provided in a nursing facility or a personal care facility

Obesity Treatment Program
Legislation passed during the 2009 Regular Session established a two-year limited program within the Plan for the treatment and management of obesity and related conditions, and includes benefits for bariatric surgery. Benefits are provided for obesity treatment services only for those participants enrolled in the Obesity Treatment Program.

Occupational Therapy
Occupational therapy services are covered when prescribed by the participant's physician and specified in a treatment plan. BCBSMS may require proof of medical necessity. Services must be provided by a licensed occupational therapist.

Physical Therapy
Physical therapy services are covered when specified in a treatment plan and provided by a licensed physical therapist. BCBSMS may require proof of medical necessity.

Physician Services
The following physician services are covered:

- In-hospital medical care
- Medical care in the physician's office, patient's home, or elsewhere
- Surgery and assistance at surgery (when appropriate and provided by a physician practicing within the scope of his license)
- Consultations
- Administration of anesthesia
- Radiation therapy
- Obstetrical care
- X-rays and laboratory tests performed in a physician's office, except when performed during routine examinations, unless applied to the wellness benefit
- Psychiatric and psychological services for mental health treatment
- Allergy testing
- Covered dental care
- Dialysis treatment

Benefits for physician services are allowed based upon the coding guidelines used by BCBSMS.

Multiple Surgery
Special rules apply to multiple surgery procedures performed by the same physician during the same operation. If more than one surgical procedure is performed during the same operation

through one or more routes of access, the allowable charge is the amount payable for the primary procedure plus 50% of the allowable charge that would be allowed for each of the additional procedures had those procedures been performed alone. Any of the costs associated with additional procedures (incidental procedures) not essential to the purpose of the primary procedure are not covered.

Prosthetic or Orthotic Devices
Covered services include the purchase and initial placement of prosthetic or orthotic devices, and the fitting, repair, or replacement when medically necessary. No shoe build-up, shoe orthotic, shoe brace, or shoe support is covered unless the shoe is attached to a brace.

Pulmonary Rehabilitation Programs
Benefits are provided for Pulmonary Rehabilitation programs. Prior approval must be obtained from BCBSMS.

Residential Treatment Facility
All admissions and continued stays in a Residential Treatment Facility must be certified as medically necessary by ActiveHealth. Refer to the *Medical Management and Utilization Review* section for certification requirements.

Skilled Nursing Facility
All admissions and continued stays in a Skilled Nursing Facility must be certified as medically necessary by ActiveHealth.

Sleep Disorders
Services and supplies for the diagnosis and treatment of Obstructive Sleep Apnea Syndrome or other sleep disorders must be received in or prescribed through a sleep disorder center or laboratory, either affiliated with a hospital or freestanding, which is accredited by the American Academy of Sleep Medicine. Participants can contact BCBSMS to locate an accredited facility. The interpretation of all sleep tests must be performed by a physician who is board certified as a sleep specialist by the American Board of Sleep Medicine. To receive maximum benefits participants must use a provider that participates in the AHS State Network.

Speech Therapy
Speech therapy services are covered if needed as the result of an illness or injury, there is a reasonable expectation that the therapy will achieve measurable improvement within a reasonable and predictable period, and services are prescribed by a physician and provided by a licensed speech therapist.

Speech therapy is not covered for maintenance speech, delayed language development, articulation disorders, learning disabilities, attention disorders, psychosocial speech delay, behavioral problems, conceptual handicap, mental retardation, stammering, or stuttering.

Substance Abuse
Benefits are provided for inpatient, residential treatment facility, intensified outpatient program, and outpatient substance abuse treatment. All inpatient hospital and residential treatment facility admissions for substance abuse treatment must be certified as medically necessary by ActiveHealth. Refer to the *Medical Management and Utilization Review* section for certification requirements.

Temporal Mandibular Joint Syndrome (TMJ)
Benefits for surgery and diagnostic services of the temporomandibular/craniomandibular joint are provided, up to a lifetime maximum benefit of $5,000. Benefits are not provided for physical therapy, orthodontics, dentures, occlusional reconstruction, or for crowns or inlays.

Transplants
All solid human organ and bone marrow/stem cell transplant evaluations and transplants must be certified as medically necessary by ActiveHealth and are subject to the following provisions:

- The condition requiring the transplant is life-threatening;
- The transplant for the condition is the subject of an ongoing phase III clinical trial or has been approved by US Food and Drug Administration;
- The procedure follows a written protocol that has been reviewed and approved by an institutional review board, federal agency, or other such organization recognized by medical specialists who have appropriate expertise; and
- The participant is a suitable candidate for the transplant under the medical protocols used by ActiveHealth.

For benefits to be paid at the in-network benefit level, the facility where the transplant is performed must be approved by ActiveHealth.

Organ Acquisition Coverage
Benefits are provided for surgical, storage, and transportation expenses incurred and directly related to the donation of an organ or bone marrow/stem cell used in a covered transplant procedure. If any organ or bone marrow/stem cell is sold rather than donated to the participant, no benefits will be payable for the purchase price. Costs related to evaluation and procurement are covered.

Travel Expenses Related to Transplant
Transportation costs of the transplant recipient and one other person to and from the surgery site, as well as reasonable and necessary cost of meals and lodging for the accompanying person, are covered. If the recipient is a minor, reasonable and necessary expenses for the transportation,

meals, and lodging of two other accompanying persons are covered. Only those travel expenses incurred at the time of the transplant surgery are eligible for reimbursement. Travel expenses incurred as a result of pre-operative and post-operative services are not eligible for reimbursement. The Plan will only reimburse actual travel expenses supported by dated receipts. The amount of reimbursement will not exceed $10,000 for any single transplant episode. Dated receipts must be submitted to BCBSMS to qualify for reimbursement.

Living Donor Coverage

The following chart summarizes when benefits are available for an organ or bone marrow/stem cell transplant from a living donor:

If…	***Then…***
Both the recipient and the donor are Plan participants…	Covered benefits provided to the donor will be applied to the recipient's Plan benefit.
Only the recipient is a Plan participant…	The donor is entitled to Plan benefits, but only to the extent coverage is not provided by another health care plan. Covered benefits provided to the donor will be applied to the recipient's Plan benefit.
When only the donor is a Plan participant…	No benefits are provided.

Benefits for the following services are provided to the donor:

- Search for matching bone marrow, or organ;
- Transportation to and from the surgery site;
- Organ or bone marrow/stem cell removal, withdrawal, and preservation; and hospitalization.

If benefits are approved, reimbursement for covered organ and bone marrow/stem cell transplants will be the same as other covered medical expenses.

Weight Management Services

A weight management program through ActiveHealth is provided for participants with a Body Mass Index of 40 or greater. This 12-month program provides individual counseling over the phone with dieticians, nurses, and fitness experts. This confidential program is available to participants at no cost.

Well-Child Care

In-Area Children

Benefits are provided for well-child care services for covered dependents up to age 18. These services are not subject to the calendar year deductible. **Benefits are only provided to in-area dependents when a participating provider renders services.**

Well-newborn nursery care while a newborn is hospital-confined after birth is covered at 100%. Well-newborn nursery care includes room, board, and other normal care provided for which a participating hospital or physician makes a charge. Also, well-child physician office visits, certain diagnostic tests, and immunizations are covered at 100%.

A list of covered preventive services can be found at the Plan's website, http://knowyourbenefits.dfa.state.ms.us or can be obtained by calling BCBSMS.

Out-of-Area Children
Benefits are provided for well-child care services for covered dependents up to age 18. These services are not subject to the calendar year deductible.

Well-newborn nursery care while a newborn is hospital-confined after birth is covered at 75% of the allowable charge when services are rendered by a non-participating provider. Well-newborn nursery care includes room, board, and other normal care provided for which a participating hospital or physician makes a charge. Also, well-child physician office visits, certain diagnostic tests, and immunizations are covered at 100% of the allowable charge when services are rendered by a non-participating provider.

A list of covered preventive services can be found at the Plan's website, http://knowyourbenefits.dfa.state.ms.us or can be obtained by calling BCBSMS.

Wellness/Preventive Coverage for Adults
In-Area Adults
Benefits will be provided at 100% of the allowable charge for up to two (2) office visits and certain diagnostic tests. These diagnostic tests are based on the participant's age and gender. These services are not subject to the calendar year deductible. **Benefits are only provided when a participating provider renders the services.** A complete list of the covered preventive services for adults can be found at the Plan's website, http://knowyourbenefits.dfa.state.ms.us or can be obtained by calling BCBSMS.

Out-of-Area Adults
Benefits will be provided at 100% of the allowable charge for up to two (2) office visits and certain diagnostic tests when services are rendered by a non-participating provider. These diagnostic tests are based on the participant's age and gender. These services are not subject to the calendar year deductible. A complete list of the covered preventive services for adults can be found at the Plan's website, http://knowyourbenefits.dfa.state.ms.us or can be obtained by calling BCBSMS.

Wound Vacuum Assisted Closure
Benefits are provided for Wound Vacuum Assisted Closure services when prescribed by the attending physician and certified by ActiveHealth to be medically necessary prior to initiation.

Medical Management and Utilization Review

ActiveHealth performs medical management services and utilization review for the Plan.

Utilization review is a process to make sure that the care participants receive is medically necessary, delivered in the most appropriate location, and follows generally accepted medical standards. Utilization review provides clinical review and certification of the medical necessity of care. **Certification of medical necessity does not guarantee that services are covered**. Benefits are subject to the patient's eligibility at the time charges are actually incurred, and to all other terms, conditions, and exclusions of the Plan.

Notification Requirements

It is the participant's responsibility to make sure that ActiveHealth is notified in advance of certain types of medical services. The notification requirements that apply to inpatient hospital admissions and specified outpatient diagnostic tests are detailed within this section.

The following services require certification and must be certified as medically necessary by ActiveHealth:

- Inpatient hospital admission
- Inpatient rehabilitation
- Residential Treatment Facility
- Outpatient CAT Scan (unless performed in emergency room setting)
- Outpatient MRI Scan (unless performed in emergency room setting)
- Private duty and home health nursing services
- Solid organ and bone marrow/stem cell transplants
- Home infusion therapy services
- Skilled Nursing Facility
- Long Term Acute Care Facility
- Hospice Care Services
- Wound Vacuum Assisted Closure
- Diabetic self-management training/education

ActiveHealth must be contacted in advance of any anticipated non-emergency hospital admission and immediately following an emergency admission by calling 866-939-4721. **Failure to comply with notification requirements will result in financial penalties, reduction of benefits, or denial of benefits.**

Note: Certification is not required for those participants having Medicare or other primary coverage, unless the service is not covered by the primary coverage. In this case, the service will be subject to the certification process.

Certifying a Hospital Admission
For certification review of non-emergency admissions to a hospital or psychiatric or chemical dependency facility, the participant is required to call ActiveHealth as soon as he is advised that he may need to be hospitalized. In all cases, the call must be made as soon as possible but at least 5 days before the admission date. It is the participant's responsibility to ensure that notification requirements are met.

Certifying Maternity Care and Hospitalization
There is an exception to the 5-day advance notification rule for maternity care. Because of the need to ensure that maternity cases receive the proper case management, call ActiveHealth:

- as soon as a pregnancy is confirmed, and
- within 48 hours of admission for delivery.

ActiveHealth must also be contacted in the following instances:

- if the newborn requires additional hospital days beyond the mother's length of stay, or
- if the mother is not a Plan participant, but the child will be enrolled in the Plan.

For instructions on adding a newborn as a dependent, see *Special Enrollment Period for Newly Acquired Dependents*.

Certifying an Emergency Hospital Admission
ActiveHealth must be notified within 48 hours of an emergency admission to a hospital. If the participant is unable to make the call, another party can make the call on the participant's behalf. However, it is the participant's responsibility to ensure that notification requirements are met.

Notification Requirements For Inpatient Hospital Admissions	
Type of Admission	***Notification Requirement***
Non-emergency	As soon as possible, but at least 5 days prior to admission
Maternity	Within 48 hours of admission
Emergency	Within 48 hours of admission

Weekend and holiday admissions must also be reported within these timeframes.

If the notification requirements are not met and the inpatient admission is later found to be medically necessary by ActiveHealth, penalties will be imposed.

Inpatient Financial Penalties:

Notification	*Definition*	*Penalty*
No Notification	Notification that occurs after discharge.	A $500 penalty will be imposed.
Late Notification	Notification that occurs: ▪ less than 5 days prior to the admission date, but prior to discharge for a non-emergency admission; or, ▪ more than 48 hours after admission, but prior to discharge for an emergency or maternity admission.	A $250 penalty will be imposed.

Specified Outpatient Diagnostic Tests
The following outpatient tests require certification by ActiveHealth (unless performed in an emergency room setting) prior to services being rendered:

- CAT Scan – excluding brain and head scans (visual x-ray of soft tissue/bones; specialized x-ray visualization of the body structures)
- MRI Scan – excluding brain and head scans (magnetic imaging of body structures)

Notification Requirements for Outpatient Diagnostic Tests	
Non-emergency	As soon as possible, but at least 48 hours prior to test being performed
Emergency	Within 48 hours of test being performed

If the participant fails to meet the notification requirements, penalties will be imposed if the test is later found to be medically necessary by ActiveHealth.

Outpatient Financial Penalty:

Notification	*Definition*	*Penalty*
No Notification	Notification that occurs any time notice is given to ActiveHealth more than 48 hours after an emergency test is performed or any time after a non-emergency test is performed.	A $100 penalty will be imposed.

Non-Certification of Medical Necessity
If ActiveHealth determines services are not medically necessary, or are being provided at a level of care inconsistent with the standard form of managed care environments, ActiveHealth will advise the participant and/or the treating physician that coverage cannot be guaranteed. **No benefits will be provided for any service related to an inpatient hospital admission or specified outpatient diagnostic test that is determined by ActiveHealth (either before or after the admission) to be not medically necessary.**

Retrospective Review
If ActiveHealth is not notified of an inpatient admission or outpatient diagnostic test, a retrospective review may be performed. A retrospective review may be performed when ActiveHealth is contacted ***after*** discharge from an inpatient admission or more than 48 hours after a specified outpatient diagnostic test was performed. Even if ActiveHealth determines that services are medically necessary, the financial penalties will apply.

Medical Case Management
ActiveHealth may perform medical case management for those participants who have a complicated, catastrophic, or chronic condition. Through medical case management, ActiveHealth may elect to (but is not required to) extend covered benefits beyond the benefit limitations and/or cover alternative benefits for cost-effective health care services and supplies that are not otherwise covered under the Plan. The decision to provide extended or alternative benefits is made on a case-by-case basis to participants who meet ActiveHealth criteria.

Disease Management Program
Plan participants with certain chronic conditions are enrolled in a disease management program, Informed Care Management, administered by ActiveHealth. The program provides help, support, and education for participants living with cardiac disease, asthma, and/or diabetes. The program is voluntary, completely confidential, and provided at no cost to participants.

Special features of the program include:

- Personalized telephonic counseling about the participant's specific health condition
- Helping the participant achieve health goals
- An individualized care plan about nutrition, exercise, and other areas
- Educational materials
- Access to community resources
- Access to health and medical topics

The program does not replace care provided by the participant's physician. For information on the program or to stop participation in the program, contact ActiveHealth at 866-939-4721.

Diabetic Self-Management Training/Education
Benefits are provided for diabetic self-management training/education at 100% of the allowable charge (not subject to the calendar year deductible) for participants enrolled in Informed Care Management.

Clinical Decision Support Program
ActiveHealth uses a CareEngine Clinical Decision Support program to identify clinical issues that physicians and patients can discuss. ActiveHealth continually monitors medical and pharmacy claims. If the program identifies drug interactions or other medical issues, the participant and his physician will receive a letter called a Care Consideration.

Pre and Post Discharge Call Services
ActiveHealth provides pre-admission educational calls for all elective inpatient surgical patients as well as outreach calls to participants after discharge. The purpose of this service is to assess the participant's level of understanding of the surgery to be performed, pre-operative testing and preparation requirements, post-surgical limitations, expected care needs and to evaluate the participant's support system/preparation in relation to post-discharge care.

Following hospital discharge ActiveHealth will follow-up with the participant telephonically to confirm any home care and/or durable medical equipment needs, assure the participant has scheduled post-acute physician visits with surgeon, specialist(s) and primary care provider as advised, confirm participant has filled required prescriptions and has resumed pre-operative medications as directed by the physician and determine if the participant has adequate support to allow him to adhere to the prescribed plan of care.

Nurse Line Services
ActiveHealth provides a 24-hour, 365-day Nurse Line for triage, self-care education, and support for participants to make good healthcare decisions. Participants calling the Nurse Line about medical issues or questions are offered general health information which can be mailed, faxed or emailed at the end of the call if requested by the participant. The Nurse Line services also provide access to an audio library of messages on general health topics. The audio library is available to all participants. The Nurse Line is also available to accept after hour telephone calls from participants and providers for purposes of certification.

Solid Organ and Bone Marrow/Stem Cell Transplant Services
ActiveHealth reviews and evaluates all requests for transplant services and makes a recommendation concerning the medical necessity of the transplant services based on the clinical data provided by the attending physician. All participants meeting certification requirements for a transplant will be immediately placed in the medical case management program. Case management of transplant services include all management necessary to coordinate pre-transplant services for the patient and family such as supportive care required for the patient while awaiting a transplant, alternative living arrangements for the patient and/or family once the

transplant has been scheduled and performed, and all necessary post transplant services to coordinate and transition care for the patient from the transplant facility to the patient's home based medical care providers.

Weight Management Services

A weight management program through ActiveHealth is provided for participants with a Body Mass Index of 40 or greater. This 12-month program provides individual counseling over the phone with dieticians, nurses, and fitness experts. This confidential program is available to participants at no cost. Call ActiveHealth at 866-939-4721 for more information.

Limitations and Exclusions

In addition to the benefit limitations and exclusions discussed elsewhere in this *Plan Document*, the following are either limited or not covered by the Plan.

Abortion	Not covered, unless documented to be medically necessary to preserve the life or physical health of the mother.
Acupuncture/Biofeedback	Not covered.
Allowable Charge	Charges exceeding the allowable charge are not covered.
Assistant at surgery	Not covered, unless services are rendered by a physician, physician assistant, or first nurse assistant.
Cardiac Rehabilitation - Outpatient	Not covered except when determined to be medically necessary by BCBSMS.
Canceled or Missed Appointments	Not covered.
Charity Hospital, Public Mental Institution, Sanatorium	Services for which the participant has no legal obligation to pay or for which no charge would be made if the participant had no health insurance coverage are not covered.
Chelation Therapy	Not covered, except for treatment of acute heavy metal poisoning.
Coding	Charges resulting from inappropriate coding, as determined by BCBSMS are not covered.
Convalescent, Custodial, or Domiciliary care	Not covered, including companions and sitters.
Co-payments, Coinsurance, Deductibles	Not covered.
Cosmetic Services	Not covered, except for correction of defects incurred by a participant while covered under the Plan through traumatic injury or disease requiring surgery.
Counseling	Sex therapy and marriage or family counseling are not covered.
Coverage Effective Dates	Services or supplies provided before coverage becomes effective or after coverage ends are not covered.
Dental Services	Not covered, except when services are provided due to an accidental injury to sound natural teeth which occurs while the participant is covered by the Plan or as a direct result of a disease covered by the Plan.

Dental Services (hospital or ambulatory surgical facility services and anesthesia)	Hospital services and supplies for dental care and treatment and dental or oral surgery are not covered unless the inpatient hospital stay is determined medically necessary by ActiveHealth. Outpatient hospital, ambulatory surgical facility, or anesthesia services are not covered unless determined medically necessary by BCBSMS.
Diabetic Self-management	Outpatient diabetic self-management training/education and medical nutrition therapy are not covered, except as provided through the disease management program of the Plan.
Educational Training	Educational training or cognitive therapy is not covered unless otherwise specified in this *Plan Document* or covered under wellness/preventive services.
Equipment	Equipment that has a non-therapeutic use (such as humidifiers, air conditioners or filters, whirlpools, wigs, vacuum cleaners, fitness supplies, etc.) is not covered.
Experimental/Investigational	Experimental/investigational treatments, procedures, facilities, equipment, and supplies are not covered, as determined by BCBSMS or ActiveHealth.
Eye Examinations	Routine eye examinations (except as provided through well-child care), eyeglasses, or contact lenses or fittings for them are not covered.
Foot Care	Palliative or cosmetic foot care is not covered.
Gene Manipulation Therapy	Not covered.
Genetic Testing or Counseling	Not covered except when determined to be medically necessary by BCBSMS.
Government Agency	Services or supplies provided by the U.S. or any other government agency, at no charge to the patient, are not covered.
Hair Loss	Services and supplies for the treatment of hair loss are not covered.
Hearing Examinations and Hearing Aids	Routine hearing examinations are not covered except for newborn screening.
Holistic Therapies	Not covered.
Hypnosis	Not covered.
Infertility Treatment, Artificial Insemination, Intrauterine Insemination, In-vitro Fertilization, or Reversal of Sterilization	Not covered.
Luxury, Deluxe, or Convenience Items	Not covered.
Massage Therapy	Not covered.
Maternity Benefits	Charges or expenses related to the pregnancy of a dependent other than the spouse are not covered.

Medical Records	Fees for medical records and claim filing are not covered.
Medicare Covered Services	Not covered to the extent that charges for such services or supplies are paid or payable under Medicare, whether or not the participant has such Medicare coverage, whether or not Medicare benefits are claimed or received, or whether or not the participant has elected to obtain such Medicare coverage if eligible.
Military Service Connected Injury/Illness	Not covered, except in those cases where enforcement would be prohibited by law.
Not Medically Necessary	Not covered.
Nursing Home, Extended Care, or Personal Care Facility	Not covered.
Obesity Treatment or Weight Loss Therapies	Not covered, regardless of any claim of medical necessity, degree of obesity, or clinical diagnosis, except as provided through the Plan's Obesity Treatment Program and wellness/preventive coverage.
Pre-existing Conditions	Not covered, except for dependent children under age 19.
Pulmonary Rehabilitation	Not covered except when determined to be medically necessary by BCBSMS.
Refractive Eye Surgery	Not covered.
Rehabilitation Services	Not covered, unless otherwise specified in this *Plan Document.*
Related Provider	Services rendered by a provider (physician or other provider) who is related to the participant by blood or marriage or who regularly resides in the participant's household are not covered.
Retainer Fees	Fees paid for the purpose of retaining the services of a health care provider are not covered.
Scope of License	Services rendered by a physician or other provider not practicing within the scope of his license at the time and place service is rendered are not covered.
Services Not Specifically Included as Benefits	Not covered.
Sex Transformations	Not covered.
Smoking Cessation Programs	Not covered.
Speech Therapy	Not covered when services are provided for maintenance speech, delayed language development, articulation disorders, learning disabilities, attention disorders, psychosocial speech delay, behavioral problems, conceptual handicap, mental retardation, stammering, or stuttering.
Telephone Consultations	Not covered.
Therapy Services	Primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, aromatherapy, colonic irrigation, reflexology, vision perception training, and carbon dioxide therapy, and related therapies are not covered.

Third Party Liability	Services related to an injury which occurs due to the wrongful act or omission of another party for which that party or some other party makes settlement or is legally responsible is not covered. However, if the participant is unable to recover from the responsible party, benefits of this Plan will be provided.
Travel	Not covered, except as provided under transplant benefits.
Visual or opthoptic training	Not covered.
War	Services rendered for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war are not covered.
Workers' Compensation Employer Liability Law	Services related to any injury or illness arising out of or in the course of employment entitling the participant to benefits under any Workers' Compensation or Employer Liability Law are not covered.

Prescription Drug Program

NOTE: This section does <u>not</u> apply to Medicare eligible retirees, Medicare eligible surviving spouses, and Medicare eligible dependents of retirees and surviving spouses.

The Plan includes a co-payment program for prescription drugs. This section summarizes the details of the program and how it works. An enrollee must elect health insurance coverage in order to participate in the prescription drug program. Refer to the sections on Base Coverage and Select Coverage for information on deductibles.

To be covered under the Plan, prescription drugs must be:

- Prescribed by a physician,
- Dispensed by a licensed pharmacist, and
- Found to be medically necessary for the treatment of the participant's illness or injury.

Participants may purchase medically necessary prescription drugs at participating retail pharmacies or through the Catalyst Rx mail order service. Specialty medications must be purchased through the Catalyst Rx Specialty Drug Management Program. Coverage for prescription drugs purchased at a retail pharmacy or through the mail order service is limited to a 90-day supply. Coverage for prescription drugs purchased through the specialty pharmacy program is limited to a 30-day supply.

When a prescription drug is purchased at a participating retail pharmacy, the participant is only required to pay the appropriate co-payment amount (after the applicable deductible is met) or the cost of the drug, whichever is less. There is no claim form to file. When a prescription drug is purchased at a non-participating pharmacy, the participant must file a claim with Catalyst Rx. Payment of the claim will be made based upon the Plan's allowable charge. The participant is responsible for any amount in excess of the allowable charge, plus the applicable deductible and/or co-payment.

Catalyst Rx Customer Service

Catalyst Rx is available 24 hours a day, 7 days a week to provide assistance to Plan participants. If a participant should experience a problem having a prescription filled or have a question regarding coverage, he may contact Catalyst Rx at 866-757-7839.

Co-Payments

Prescription drug co-payments for retail pharmacies and the mail order service are as follows:

	Retail Pharmacies			Mail Order
Prescription Drug Type	**1-30 Day Supply**	**31-60 Day Supply**	**61-90 Day Supply**	**90 Day Supply (or less)**
Generic Drug	**$12**	**$24**	**$36**	**$24**
Preferred Brand Drug	**$40**	**$80**	**$120**	**$80**
Other/Non-Preferred Drug	**$65**	**$130**	**$195**	**$130**

Co-payments for diabetic supplies are as follows:

	Retail Pharmacies			Diabetic Sense
Testing Strips and Lancets	**1-30 Day Supply**	**31-60 Day Supply**	**61-90 Day Supply**	**90 Day Supply (or less)**
Preferred Brand	**$12**	**$24**	**$36**	**$24**
Non-Preferred Brand	**$40**	**$80**	**$120**	**N/A**

In most instances, when a generic drug is available and the participant purchases the brand name drug, the participant will pay the difference in the cost of the brand name drug and the generic drug, plus the generic co-payment amount.

Based on the cost of some generic drugs, co-payment other than the generic co-payment may apply.

The co-payment amount of certain covered prescription drugs may be reduced, increased, or eliminated to assist in controlling prescription drug costs.

NOTE: Participants in Base Coverage will be charged the full allowable charge until the annual deductible is met.

Generic Drugs

Typically, generic drugs cost less than equivalent brand-name drugs. Because the generic drug co-payment is less, participants save money when purchasing generic drugs. Participants are encouraged to use generic drugs whenever allowed by their physician. To be covered by the Plan, a generic drug must:

- Contain the same active ingredients as the brand-name drug (inactive ingredients may vary);
- Be identical in strength, form of dosage, and the way it is taken;

- Demonstrate bio-equivalence with the brand-name drug; and
- Have the same indications, dosage recommendations, and other label instructions (unless protected by patent or otherwise exclusive to the brand-name).

Preferred Brand Drugs

A list of preferred brand drugs is maintained by Catalyst Rx. Preferred drugs are chosen based on their clinical appropriateness and cost effectiveness. Catalyst Rx has the right to add drugs to the list at any time. Deletions will typically only occur on an annual basis. A copy of the list can be obtained by contacting Catalyst Rx directly or through the Plan's website at http://knowyourbenefits.dfa.state.ms.us.

Vaccine Program

Benefits will be provided at 100% of the allowable charge for annual influenza (flu) and pneumococcal infection (pneumonia) vaccines administered by an immunization-certified pharmacist at a participating pharmacy. In addition, benefits will be provided at 100% of the allowable charge for participants age 60 and over who receive the herpes zoster (shingles) vaccine from an immunization-certified pharmacist. Participants must use a CatalystRx participating pharmacy.

Mail Order Service

Plan participants can enjoy the convenience of home delivery by using Catalyst Rx's mail order program.

In order to participate in the mail order program, participants must register as a first time user. Registering will establish your health, allergy, and payment information.

2 Steps to Enroll in the Mail Order Service

- Call your physician and obtain a new 90-day prescription.
- Complete the Catalyst Rx mail order program Enrollment Form
    - Initial registration can be completed
        - online at www.catalystrx.com via the "Mail Service" link,
        - by calling 866-757-7839 and selecting Option 1,
        - by printing the form and mailing to the address on the form
    - Prescription Order Form can be:
        - faxed to the Catalyst Rx mail order program by the physician's office or
        - mailed to the Catalyst Rx mail order program by the participant

Order refills 7-10 days before your supply runs out. This will allow ample time for shipping and delivery of your order.

Some Helpful Tips When Using The Order Service

- **Verify the deductible and/or co-payment amount by calling Catalyst Rx at 866-757-7839.**
- **Make sure the prescription is written for a 90-day supply.**
- **To ensure the order is not held up due to insufficient payment, be sure to provide a valid credit card number during the registration process. Catalyst Rx will contact the participant to authorize any co-payment amounts more than $205 above the expected co-payment before billing the credit card.**
- **Please allow 7-10 days for your order.**
- **You may also obtain additional mail order registration forms and prescription order forms on the Plan's website at knowyourbenefits.dfa.state.ms.us**

A prescription submitted to the mail order service for less than a 90-day supply will be charged the same co-payment as for an entire 90-day supply. Catalyst Rx has the right to stop mail order service if an enrollee carries a delinquent balance on his account.

A mail order co-payment will be applied to each unit for any covered drug or medical item that requires a specific co-payment per unit or vial, such as insulin.

Catalyst Rx can be contacted by calling 866-757-7839 and selecting Option 1.

Prior Authorization

Certain prescription drugs require prior approval. The prescribing physician must contact Catalyst Rx at 866-757-7839 for prior authorization. The physician must provide appropriate documentation of medical necessity. Only the physician can request prior authorization approval.

Examples of prescription drugs requiring prior authorization include, but are not limited to:

- medications for treating acne,
- anabolic steroids,
- medications for tobacco cessation,
- brand name proton pump inhibitors,
- medications for male impotency, and
- growth hormones for persons age 21 or older.

The quantity of some prescription drugs may be limited based on medical necessity. Some prescription drugs are indicated only for a specific therapeutic period or in certain amounts. If the quantity of a covered prescription drug, as prescribed by the physician, is not approved by Catalyst Rx, the physician must contact Catalyst Rx for prior approval of additional quantities. Approval will require appropriate documentation of medical necessity.

The fact that a physician has prescribed, ordered, recommended, or approved a prescription drug, does not, in itself, make the prescription drug medically necessary for purposes of coverage under the Plan.

Step Therapy
Some prescription drugs require step therapy. Step therapy is a process that optimizes rational drug therapy while controlling costs by defining how and when a particular drug or drug class should be used based on a patient's drug history. Step therapy requires the use of one or more prerequisite drugs that meet specific conditions prior to the use of another drug or drugs.

Early Refills
There are some circumstances when a participant will be allowed to obtain an early refill of a prescription drug for purposes such as going on vacation, for a dosage change during the course of a treatment, or for lost or destroyed medication. The participant's pharmacist may contact Catalyst Rx to obtain authorization for an early refill or advance supply of a medication. Early refills are limited to two refills per medication per 12 months.

Catalyst Rx Specialty Drug Management Program
The Catalyst Rx Specialty Drug Management Program, supported by Walgreens Specialty Pharmacy and other approved pharmacies, provides access to specialty medications with the convenience of express mail delivery. Specialty medications must be purchased through this program in order to be covered. Participants have access to a Specialty Care Team staffed by experienced pharmacists specially trained in complex health conditions and the latest medication therapies. Participants can call the Walgreens Specialty Pharmacy at 866-823-2712 for more information or CatalystRx at 866-757-7839 for information on other approved pharmacies. The following chart shows the co-payment amount for specialty medications.

	In-Network (30-day supply)	Out-of-Network
Specialty Drugs	$65	*N/A

*There is no Out-of-Network co-payment since all specialty drugs must be purchased through the CatalystRx Specialty Drug Management Program (In-Network).

This program provides medications for many chronic conditions, including the following:

Multiple Sclerosis
Gaucher's Disease
Hepatitis C
Respiratory Syncytial Virus
Crohn's Disease
Pulmonary Hypertension
Rheumatoid Arthritis
Cystic Fibrosis
Anemia
Growth Hormone Deficiency
Neutropenia

Limited Distribution Drugs
Limited distribution drugs are only available through select specialty providers as determined by the drug manufacturer. Access to limited distribution drugs is available through other specialty providers in the Catalyst Rx Specialty Management Program. For assistance with obtaining a limited distribution drug and with locating an approved distributor, contact Catalyst Rx at 866-757-7839.

Diabetic Sense
To help meet the needs of members with diabetes, Catalyst Rx offers the **Diabetic Sense** program. To enroll or learn more, please contact Diabetic Sense at 877-852-3512.

Some of the benefits of the Diabetic Sense program are:

- Free blood glucose meters as provided through Diabetic Sense
- Participants receive a 90-day supply of diabetic supplies (see copayment chart) for 2 generic copayments through mail
- Educational materials
- Access to certified diabetes educators and registered pharmacists

Tobacco Cessation
Coverage is provided for tobacco cessation prescription and over-the-counter drugs. A prescription is required. Benefits will be provided at 100%, not subject to the calendar year deductible, with an annual limit of 2 cycles (12 weeks per cycle).

Coordination of Benefits
When a participant has other health insurance coverage which is primary, a claim may be filed for secondary coverage under the Plan. To file a claim, a copy of the explanation of benefits from the primary insurance carrier along with a copy of the receipt from the pharmacy must be attached to a Direct Member Reimbursement (DMR) form. The form may be obtained from Catalyst Rx by calling 866-757-7839 or at www.catalystrx.com. The claim is processed by Catalyst Rx and reimbursement is made to the enrollee based upon the Plan's allowable charge, less the amount paid by the primary carrier, less the applicable co-payment for that prescription drug.

Covered Drugs
The following types of drugs and medical items are covered by the Plan:

Covered Drug	***Limitations/Requirements***
▪ Legend Drugs and Legend Contraceptives	Federal law requires these drugs be dispensed by prescription only
▪ Compounded medication	At least one ingredient must be a Legend Drug
▪ Disposable blood/urine glucose/acetone testing agents	1 Generic co-payment per 30 day supply

▪ Disposable insulin needles/syringes	1 Generic co-payment per 30 day supply
▪ Glucagon	1 Preferred brand drug co-payment per each single unit
▪ Insulin	1 Generic co-payment per 30 day supply
▪ Lancets	1 Generic co-payment per 30 day supply
▪ Growth hormones	For individuals through the age of 20 years
▪ Aspirin	For participants age 45 and older (prescription required)
▪ Iron Supplements	For children up to age 1 (prescription required)

What Drugs Are Not Covered?

The following drugs and medical items are not covered under the prescription drug program:

- Anabolic steroids for muscle enhancement
- Anorectics [any drug used for the purpose of weight loss]
- Anti-wrinkle agents
- Charges for administration or injection of any drug, except as provided through the Vaccine Program
- Dietary supplements
- Fluoride supplements (except for children up to age 5, prescription required)
- Hematinics
- Infertility medications
- Minerals (except for iron supplements for children up to age 1, prescription required)
- Medications for the termination of pregnancy (abortifacients)
- Any medication not proven effective in general medical practice
- Investigative drugs and drugs used other than for the FDA approved diagnosis
- Immunizations for prevention of infectious diseases (e.g., measles, polio, etc.) except as provided through the Vaccine Program
- Drugs prescribed by a provider not acting within the scope of his license
- Drugs furnished at no cost to the patient by the local, state, or federal government
- More than the recommended daily dosage
- Drugs that, by FDA guidelines, do not require a written prescription (except as otherwise noted)
- Medications for the treatment of alopecia
- Non-legend drugs other than those listed as covered
- Pigmenting/de-pigmenting agents
- Drugs used for cosmetic purposes
- Therapeutic devices or appliances, including needles, syringes, support garments, and other non-medicinal substances, regardless of intended use, except those listed as covered above (some of these items may be covered under the Plan's medical benefits)
- Vitamins, singly or in combination (except legend prenatal vitamins and folic acid for women up to age 55, prescription required)
- Prescription drugs that have an equivalent product available over the counter
- Refills in excess of the number specified by the physician or any refills dispensed more than one year after the date of physician's original prescription.
- Drugs paid for any Workers' Compensation coverage
- Drugs considered not medically necessary

Retiree Eligibility and Medical Coverage

Retiree Eligibility
To be eligible for retiree health coverage under the Plan, an active employee must be enrolled in the Plan on the day before the effective date of retirement and:

- Participate in a retirement plan approved by the Mississippi Public Employees' Retirement System (PERS),
- Participate in the State and School Employees' Health Insurance Plan for 4 years or more (unless retiring due to work-related disability),
  and
- Qualify for service retirement under the applicable PERS regulations, or
- Be approved for disability retirement benefits by PERS, or
- Be an elected state or district official who does not run for reelection or who is defeated.

Note: Refer to the Group Term Life Insurance section for information on applying for life insurance coverage as a retiring employee or totally disabled employee.

Retiree Enrollment
An employee must apply for retiree coverage at least 31 days prior to their retirement date to avoid a temporary lapse in coverage. The *Application for Coverage* form must be received within 31 days of losing coverage as an employee. If the form is received more than 31 days after coverage as an employee has terminated, the right to continue medical coverage as a retiree will be forfeited. The effective date of the retiree coverage will be the first day of the month following termination as an active employee.

Retiree Coverage Checklist
Be sure to complete the following checklist to enroll for retiree health and life benefits:

- ✓ **Complete a health insurance *Application for Coverage* form and a life insurance *Enrollment/Change Request Form***
- ✓ **Submit 1st month's premium made payable to the State/School Insurance Fund (if submitted within 31 days of losing coverage, 2 month's premium is required)**
- ✓ **Submit a copy of the final Estimate of Benefits provided by PERS**
- ✓ **Submit copy of PERS disability approval letter (if applicable)**

This information must be returned to the employee's Human Resources office 31 days prior to the retirement date.

Reminder: If you or your spouse is eligible for Medicare, contact your local Social Security Administration office to enroll in Parts A, B, and D of Medicare.

In the event an employee does not enroll for retiree coverage within 31 days of leaving employment, he may still choose to continue coverage through COBRA any time during the balance of the COBRA election period. However, once the COBRA election period expires, the retiree has no option for coverage under the Plan. See specific details regarding COBRA continuation coverage under *Continuing Coverage Under the Plan.*

If an employee applies for disability retirement through PERS and is not eligible for service retirement, the employee must continue coverage under COBRA until disability retirement is approved in order to continue health insurance coverage under the Plan as a retiree. If disability retirement is approved by PERS, an enrollee must complete an Application for Coverage form within 31 days of approval.

Surviving Spouse Eligibility

If a covered retiree or a covered active employee who is eligible to retire dies, his covered surviving spouse and any covered dependent children may continue coverage under the Plan. The surviving spouse can be covered for his lifetime, and dependent children may be covered under the surviving spouse's coverage until they reach age 26.

If the retiree or active employee has covered dependent children but not a covered spouse, the dependent children can continue coverage for up to 36 months under COBRA continuation coverage. See specific details regarding COBRA continuation coverage and the election period under *Continuing Coverage Under the Plan.*

Surviving Spouse Enrollment

To continue coverage under the Plan, the surviving spouse must apply within 60 days of the end of the month following the employee's (or retiree's) date of death. An *Application for Coverage* form can be obtained by contacting BCBSMS.

The surviving spouse must return the *Application for Coverage* form to the Department of Finance and Administration, Office of Insurance along with all premiums due for the coverage period beginning at the first of the month following the employee/retiree's death. Any *Application for Coverage* form received by the Department of Finance and Administration, Office of Insurance more than 60 days after the employee's (or retiree's) date of death will be returned, and coverage will not be available.

Cost of Retiree / Surviving Spouse Coverage

The retiree (or surviving spouse) is responsible for paying 100% of the premium for the coverage selected for himself and any covered dependent(s). Premiums will be deducted from the retiree's monthly PERS retirement benefit, the surviving spouse's monthly PERS survivor benefit, or the retiree (or surviving spouse) will be direct billed by BCBSMS if the monthly PERS benefit is insufficient will not cover the cost of the premium. For direct bill participants, premium payments are due on the first of each month.

Open Enrollment
Retirees cannot add dependents during open enrollment. A non-Medicare eligible retiree or surviving spouse may choose either Base Coverage or Select Coverage during open enrollment.

Special Enrollment Periods resulting from loss of coverage
A dependent of a covered retiree (or surviving spouse) who loses coverage under another health plan will be eligible to enroll for coverage in the Plan if the following apply:

- The retiree (or surviving spouse) declined coverage for his dependents when first eligible because the dependent was covered by other health insurance coverage; and
- The dependent lost other coverage as a result of any of the following qualifying events:
  - Divorce.
  - The dependent is no longer eligible for coverage. (Loss of coverage due to non-payment of premiums does not qualify.)
  - The employer ceased to contribute toward the cost of the other health plan, and it was terminated.
  - The dependent's COBRA continuation coverage has expired.

To enroll for coverage under these circumstances, an *Application for Coverage* form must be submitted within 60 days of losing coverage under the other plan and appropriate premium payments must be made. As part of the application process, proof of loss of coverage must be provided. If these requirements are met, coverage under the Plan will take effect the first day following the loss of other coverage.

Special Enrollment Period as a result of gaining a new dependent
A retiree (or surviving spouse) may enroll a new dependent if the new dependent was acquired as a result of any of the following qualifying events:

- Marriage,
- Birth,
- Adoption, or placement in anticipation of adoption,
- Legal guardianship,
- Legal custody, or
- Qualified Medical Child Support Order (QMCSO)

To enroll the new dependent, an *Application for Coverage* form must be submitted to BCBSMS within 60 days of the date of the qualifying event and the appropriate premiums must be paid. Any *Application for Coverage* form received by BCBSMS more than 60 days from the date of the qualifying event will be returned, and coverage will not be available.

As part of the application process, proof of the qualifying event may be required. If these requirements are met, coverage under the Plan will take effect on the date of the qualifying event. In the case of a QMCSO, the coverage will be effective the 1st day of the month following the date of the Order.

Right to Request Documentation
If requested, documentation of dependent relationship, such as marriage license or birth certificate, must be provided. To enroll a child due to adoption, placement in anticipation of adoption, legal guardianship, or legal custody, a copy of the applicable court order must be submitted with the *Application for Coverage* form.

Transferring Dependent Coverage
A retiree may transfer dependent coverage from another contract under the Plan. For example: A retiree's spouse has coverage under the Plan as an active employee, the spouse terminates employment and is not eligible to retire. The retiree can add the spouse and any other dependents covered under the spouse's contract. The retiree must complete an *Application for Coverage* form within 60 days of the spouse leaving employment and pay the appropriate premiums. Any *Application for Coverage* form received by BCBSMS more than 60 days from the date the spouse loses coverage due to termination of employment will be returned, and coverage will not be available.

Retiree Reemployment
A covered retiree who returns to work (other than full-time) with a covered employer unit while continuing to receive retirement benefits will remain covered as a retired employee. The retired employee will not be eligible for employer-paid coverage as an active employee under the Plan. This does not include retirees from the Mississippi Safety Patrol Retirement System.

A retiree who returns to full-time employment with a covered employer unit and terminates retirement benefits is eligible for employer-paid coverage as an active employee.

Changes in Enrollment Status
Any change in enrollment status, such as death, divorce, entitlement to Medicare, etc., must be reported to BCBSMS as soon as possible. The change must be made on an *Application for Coverage* form. This form may be obtained from BCBSMS.

SPECIAL NOTE ON MEDICARE ELIGIBILITY:
It is a retiree's (or surviving spouse's) responsibility to contact BCBSMS when the retiree or a covered dependent becomes entitled to Medicare (upon reaching age 65 or eligibility through Social Security disability).

Non-Medicare Eligible Retirees, Surviving Spouses, and Dependents
The Plan is the primary payer for a retired employee, surviving spouse, or dependent of a retired employee or surviving spouse who is under age 65, is not on Social Security disability, and is not covered as an active employee under another plan. Non-Medicare eligible retirees and surviving spouses may choose Select Coverage or Base Coverage. Plan primary benefits are found in *Summaries of Benefits* and *Covered Services* sections of this *Plan Document.*

Medicare Retirees, Surviving Spouses, and Dependents
Medicare is the primary payer for a retired employee, surviving spouse, or dependent of a retired employee or surviving spouse who is:

Age 65 or older.
Under age 65 with Social Security disability.
Under age 65 with end-stage renal disease after the first 30 months of Medicare eligibility.

Medicare coordination provisions are subject to change in accordance with changes in the federal Medicare program.

When Medicare is primary, the Plan will provide 100% toward the Medicare deductible and coinsurance amounts not covered by Medicare. The Plan only provides benefits for covered expenses outlined in this *Plan Document*.

Benefits are allowed based on the difference between the Medicare maximum allowable charge and the amount Medicare paid (or the difference between the Medicare allowed amount and the amount Medicare paid if assignment is accepted by the provider). This provision applies regardless of whether or not the provider participates in Medicare or contracts directly with the participant. Benefits are paid for a covered expense that is not covered by Medicare.

If a retired employee, dependent of a retired employee, surviving spouse, or dependent of a surviving spouse is eligible for Medicare and does not elect Medicare Part A or B, benefits will be reduced as though Medicare is the primary payer. The Plan will calculate benefits assuming the participant has both Medicare A and B. **It is important to enroll in Medicare Parts A, B, and D to receive maximum benefits.**

Once a retiree is approved for Medicare due to Social Security disability, the Plan will update their records to reflect Medicare as the primary coverage effective the date of Medicare eligibility. The Plan will also refund any overpayment of premiums and reprocess claims to calculate benefits as secondary to Medicare retroactive to the effective date of Medicare.

Prescription Drug Program
The Plan provides prescription drug coverage for Non-Medicare Eligible Retirees, Non-Medicare Eligible Surviving Spouses, and Non-Medicare Eligible Dependents of Retirees and Surviving Spouses. See the *Prescription Drug Program* section for a description of the prescription drug coverage.

THE PLAN DOES NOT PROVIDE PRESCRIPTION DRUG COVERAGE FOR MEDICARE ELIGIBLE RETIREES, MEDICARE ELIGIBLE SURVIVING SPOUSES, OR MEDICARE ELIGIBLE DEPENDENTS OF RETIREES AND SURVIVING SPOUSES.

Limitations and Exclusions
The limitations and exclusions are the same for all Plan participants, regardless of how Medicare pays.

Canceling Coverage
A retiree must send a written request to BCBSMS to cancel coverage under the Plan. The coverage will end at the end of the month in which the written request is received. Coverage will also end if any required contributions are not paid, or if the Plan is terminated for some reason. Dependent coverage ends at the same time the retiree coverage ends or at the end of the month in which the Plan is made aware that a dependent is no longer eligible. Requests for retroactive cancellation are not allowed.

Termination of coverage ends all rights of the enrollee to benefits under the Plan as of the date coverage ends.

Continuing Coverage Under the Plan

Continuing Coverage Under the Plan (other than continuing coverage as a retiree)
In certain situations, coverage may be extended for an employee and covered eligible dependents at group rates. For information on continuing coverage as a retiree, refer to the *Retiree Eligibility* section. The following chart summarizes the circumstances in which coverage may be continued under the Plan.

IF …	***COVERAGE MAY BE EXTENDED…***
An employee is no longer receiving pay from his employer and has been approved **for a leave of absence without pay**	For **up to 12 months** for both the employee and his covered dependents. *The employee can contact his Human Resources office for more details.*
An employee is placed on **involuntary furlough without pay**	Until the employee returns from furlough to full-time employment. *The employee can contact his Human Resources office for more details.*
An active employee is called to active military duty	For up to 24 months under COBRA.
An employee dies while **not yet eligible to retire, dependents may be eligible to extend coverage**	For up to **36 months** under COBRA for any covered dependents. *See below for exceptions.*
An employee dies while **eligible to retire and his spouse and children are covered as dependents**	For the **rest of the covered spouse's lifetime** and **until any covered dependent children reach age 26.** See *Surviving Spouse Eligibility and Enrollment* in this section.
An employee dies while eligible to retire **and his children are covered as dependents**	For up to **36 months** under COBRA for any covered dependent children.

Exceptions for a surviving spouse of an employee who dies while not yet eligible to retire.

- **If a covered surviving spouse is on Medicare at the time of the employee's death, he will be eligible to continue coverage for up to 36 months under COBRA. Medicare will be the primary payer.**
- **If a covered surviving spouse enrolls in Medicare at any time after COBRA continuation has begun, coverage will terminate.**

Active Military Duty
If an employee is called to active military duty and elects not to continue coverage under the Plan while on active duty, the employee may re-enroll for coverage upon return from active duty. The employee must apply for coverage within 31 days from the date he returns from active duty. The pre-existing condition exclusion period will be waived to the extent the employee and any covered dependents had previously satisfied the exclusion period before active duty began, if the employee applies for coverage within the 31-day period. If the employee returns within the same calendar year and applies for coverage within the 31-day period, the employee and any covered dependents will not be required to satisfy a new calendar year deductible.

What Are COBRA Benefits?
COBRA (short for Consolidated Omnibus Budget Reconciliation Act of 1986) is a federal law that allows for continuation of coverage under an employer's group health plan to covered persons (called "qualified beneficiaries") in the event of a qualifying event.

Who is a Qualified Beneficiary?
A qualified beneficiary is an individual who, on the day before the qualifying event, is covered under the Plan either as an employee, enrollee's dependent spouse, or enrollee's dependent child. A qualified beneficiary is also a child born to the employee, or who is placed for adoption with the employee during a period of COBRA continuation coverage.

What is a Qualifying Event?
A qualifying event is an occurrence which, but for the continuation coverage available under the Plan, would result in the loss of coverage for a qualified beneficiary.

Under COBRA, qualifying events include the loss of coverage that otherwise would result due to:

- Termination of employment, for reasons other than gross misconduct
- Reduction in hours of employment
- Death of the enrollee
- Divorce or legal separation
- Entitlement to Medicare
- Loss of dependent eligibility

If the qualifying event is divorce, legal separation, or ineligibility of a dependent child, the employee or qualified beneficiary must notify the employee's employer unit no later than 60 days after the qualifying event occurs; otherwise, continuation coverage may not be made available. Any other enrollee or his qualified beneficiary must notify BCBSMS no later than 60 days after the qualifying event occurs; otherwise, continuation coverage may not be made available.

An **active employee** covered by the Plan is eligible for COBRA as follows:

If an employee loses coverage under the Plan due to….	***Continuation of coverage under COBRA may extend for…***
• A reduction in hours of employment • Termination of employment (for reasons other than gross misconduct)	Up to 18 months.
• Being called to active military duty	Up to 24 months

A **spouse** is eligible for COBRA as follows:

If a spouse loses coverage under the Plan due to…	***Continuation of coverage under COBRA may extend for…***
• The death of the enrollee	Up to 36 months (unless enrollee was retired or eligible to retire)
• Termination of employee's employment (for reasons other than gross misconduct) • Reduction in employee's hours	Up to 18 months
• Employee being called to active military duty	Up to 24 months
• Divorce or legal separation • COBRA participant becomes entitled to Medicare	Up to 36 months

Dependent children are eligible for COBRA as follows:

If a dependent child loses coverage under the Plan because of...	***Continuation of coverage under COBRA may extend for…***
• The death of the enrollee	Up to 36 months, unless eligible for coverage as a dependent of a surviving spouse.
• Termination of employee's employment (for reasons other than gross misconduct) • Reduction in employee's hours	Up to 18 months
• A parent being called to active military duty	Up to 24 months
• A parent's divorce or legal separation • COBRA participant becomes entitled to Medicare • No longer being an eligible dependent under the Plan	Up to 36 months

If another qualifying event occurs during an 18 month continuation coverage period, then the period of continuation coverage can be extended, but not to exceed 36 months from the date of employment termination or reduction of hours of the employee.

Disability Extension

An 11-month coverage extension, in addition to the initial 18 months, may be granted to qualified beneficiaries who were disabled (as defined and determined under the Social Security Act) at the time of the qualifying event or at any time during the first 60 days of COBRA continuation coverage. BCBSMS must receive a copy of the Social Security Administration's disability determination notice within 60 days of the qualified beneficiary receiving the notice and before the end of the initial 18-month period of continuation coverage to be eligible for this extension.

Cost for COBRA Continuation Coverage

The qualified beneficiary is responsible for the entire cost for his COBRA continuation coverage. The premiums charged for the initial 18-month COBRA coverage period are limited by law to 102% of the regular Plan premiums. If there is an 11-month coverage extension, the premiums charged for coverage during the extended period are limited by law to 150% of the regular Plan premiums. Payment of premiums must be made within 30 days of the due date.

COBRA Continuation Coverage Checklist:

- ✓ **A COBRA election form must be completed and returned to BCBSMS within 60 days of the date coverage ended or the date of the notice, whichever is later.**
- ✓ **The first premium payment must be made within 45 days from the date of election to continue coverage.**
- ✓ **The first payment must include all premiums due for the coverage period beginning with the COBRA coverage effective date through the current month.**

Qualified beneficiaries will have continuous coverage through the COBRA election period as long as the applicable premiums are paid. If the required premium payment is not received within the 45-day period, coverage will terminate retroactively to the date of the qualifying event.

COBRA Benefits and Premium Changes

Benefits provided under COBRA continuation coverage are the same that the Plan provides to other participants under the Plan who are not receiving COBRA continuation coverage. Benefits and premiums under the Plan are subject to change at the discretion of the State and School Employees Health Insurance Management Board.

Dependent Coverage for COBRA Participants

A qualified beneficiary who has elected COBRA continuation coverage can choose to cover a newborn child, adopted child, or a new spouse who joins the family of the qualified beneficiary on or after the date of the qualifying event, subject to Plan enrollment period provisions as to when an eligible dependent may be enrolled. Coverage of such new family members ceases at the same time as the continuation coverage of the qualified beneficiary. New family members, except for children born to the covered employee or placed for adoption with the covered employee, do not become qualified beneficiaries.

Claims Administration

Verifying Coverage of a Service
To have a procedure or service reviewed for medical necessity prior to the service being performed, the participant's provider may write a pre-determination letter describing the condition and treatment. The provider's letter must include the enrollee's name and identification number, the patient's name, and pertinent medical information. The letter should be sent to BCBSMS. For all inpatient hospital services and the specified diagnostic tests listed in the *Medical Management and Utilization Review* section contact ActiveHealth at 866-939-4721.

How to File a Medical Claim
A claim must be filed before benefits can be determined. The claim must contain all of the information needed by BCBSMS to process the claim. Network providers have agreed to file claims for participants. See *Time Limit for Claims Filing*.

For care received from a non-participating provider, a participant must receive the proper itemized bills from the provider and file a claim. A participant can get a medical claim form from his Human Resources office or from BCBSMS. The form must be completed in its entirety to avoid delays in processing. Completed medical claim forms must be mailed to BCBSMS.

- ***If another plan is primary,*** the claim must be filed with that plan first. Once an explanation of benefits (EOB) from the other plan has been received, the claim must be filed with BCBSMS. The claim must be filed with a copy of the other plan's EOB. If the other plan's EOB is not attached, the claim will be denied until the information is received.

- ***If Medicare is primary***, the claim must be filed with Medicare first. Once an explanation of Medicare benefits has been received, the claim must be filed with BCBSMS. The claim must be filed with a copy of the explanation of Medicare benefits. If the explanation of Medicare benefits is not attached, the claim will be denied until the information is received.

How to File a Prescription Drug Claim
If a participant uses a pharmacy that participates in the prescription drug program, there is no claim to file. The participant will pay the applicable deductible and co-payment at the time of purchase. The prescription drug deductible and co-payment are the participant's responsibility and will not be reimbursed under the prescription drug program or the medical program. See *Time Limit for Claims Filing.*

- ***If a participant uses a pharmacy that does not participate in the prescription drug program***, a paper claim must be filed. A participant can get a prescription drug claim form by contacting Catalyst Rx. The claim form must be completed in its entirety to avoid delays in processing. Pharmacy receipts must be attached to the claim form. The completed form

must be mailed to Catalyst Rx. The participant will be reimbursed the difference between the Plan's allowable charge and the co-payment amount, once the applicable deductible has been met. Any charge for a prescription drug that exceeds the Plan's allowable charge will be the participant's responsibility and will not be applied toward meeting the deductible or co-payment.

- ***If another plan is primary***, the claim must be filed with that plan first. When an explanation of benefits (EOB) from the other plan has been received, the claim must be filed with Catalyst Rx. The claim must be filed with a copy of the other plan's EOB and the pharmacy receipts. If the other plan's EOB is not received, the claim will be denied until the information is received.

Time Limit for Claims Filing
A claim should be filed as soon as possible after receiving care.

- Deadline for Filing Medical Claims: All claims and any additional information requested must be filed with BCBSMS by the end of the calendar year following the year in which the services were provided.
- Deadline for Filing Prescription Drug Claims: All claims and any additional information requested must be filed with Catalyst Rx by the end of the calendar year following the year in which the services were provided.

A Special Note about Medical Claims: *BCBSMS does not consider a claim to be received for processing until the claim is actually received in the proper form, with all of the necessary information provided. If BCBSMS needs additional information before the claim can be processed, that information must be promptly submitted. It is the participant's responsibility to ensure that claims are filed within the time limits. Claims filed after the time limits have expired are not eligible for benefits and will be denied.*

Tips for Filing Claims
- ✓ **Keep all receipts from non-participating pharmacies and physicians.**
- ✓ **File claims promptly.**
- ✓ **Use the correct form. (There are separate claim forms for medical and prescription drug benefits.)**
- ✓ **Complete the entire form.**
- ✓ **Keep a copy of all claims filed.**
- ✓ **Mail the claim to the correct address.**

Direction of Pay
All benefits payable by the Plan are assignable only to participating providers. The Plan has the right to make payment to covered providers for covered services that they provide while there is in effect an agreement between the Plan's network and the provider allowing for direct payment. In the absence of such an agreement, the Plan, at its discretion, may pay to the enrollee and only the enrollee any benefits allowed herein. In addition, the Plan reserves the right not to recognize

an enrollee's attempted assignment to, or direction to pay, another. If a covered provider has not been offered an agreement to participate in the Plan's network, the Plan will recognize an enrollee's direction to pay the provider. To the extent permitted by law, neither the benefits nor payments under the Plan will be subject to the claim of creditors or any legal process.

Patient Audit Program

Participants are encouraged to be a patient-auditor. Participants should check medical bills to be sure they are correct. The Patient Audit Program provides a financial incentive for participants to help lower the Plan's cost as well as their own coinsurance costs for health care. This financial incentive is 50% of the amount recovered by the Plan due to a billing error, up to a maximum of $1,000 per calendar year per participant.

A patient audit incentive payment will be issued when **all** of the following occur:

1. Incorrect claim for covered medical expense is filed and benefits are paid,
2. The participant verifies with the provider that there is an error in the bill,
3. A corrected claim is filed, benefits are adjusted, and the overpayment is recovered by the Plan, and
4. Written request for a patient audit incentive payment is sent to the Department of Finance and Administration, Office of Insurance.

Information required when requesting a patient audit incentive payment includes copies of the original and revised billings from the provider, both the incorrect and adjusted explanation of benefits from BCBSMS, and copies of any other available documentation relative to the overpayment and/or adjustment of the claim. Failure to provide the required documentation and related information will result in the request to receive an incentive payment from the Patient Audit Program being denied.

If the Department of Finance and Administration, Office of Insurance determines that an overcharge was made, 50% of the amount refunded to the Plan, up to a maximum of $1,000 per calendar year, will be paid to the enrollee. If it is determined that no error was made or that the request does not qualify under the Patient Audit Program, an explanation will be sent. Payment errors made as a result of BCBSMS' actions are not eligible for patient audit incentive payments.

In the event a patient audit incentive payment request is made on behalf of a deceased Plan participant, legal proof of the identity and address of the administrator of the Plan participant's estate and information as to the status of the estate will be required.

General Claims Process Information

There are different categories of claims that can be made under the Plan. A claim is a pre-service claim if it requires certification of medical necessity in advance of obtaining the medical care. An urgent care claim is a special type of pre-service claim. A claim involving urgent care is any pre-service claim for medical care or treatment when the time periods that otherwise apply to pre-service claims could seriously jeopardize the participant's life or health or ability to regain maximum function or would—in the opinion of a physician with knowledge of the participant's

medical condition—subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim or an urgent care claim.

The Plan will decide an initial pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the certification request. The Plan will decide an initial urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the certification request. The Plan will decide an initial post-service claim within a reasonable time but no later than 30 days after receipt of the claim.

Despite the specified timeframes, nothing prevents the participant from voluntarily agreeing to extend the above timeframes. In addition, if the Plan is not able to decide a pre-service or post-service claim within the above timeframes, due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that the participant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The extension notice will include a description of the matters beyond the Plan's control that justify the extension and the date by which a decision is expected. No extension is permitted for urgent care claims.

In the case of an incorrectly filed pre-service claim, the participant will be notified as soon as possible but no later than 5 days following receipt by the Plan of the incorrectly filed claim; and (b) in the case of an incorrectly filed urgent care claim, the participant will be notified as soon as possible but no later than 24 hours following receipt by the Plan of the incorrectly filed claim. The notice will explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless written notice is specifically requested by the participant.

If an urgent care claim is incomplete, the Plan will notify the participant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notification may be made orally to the participant, unless the participant requests written notice, and it will describe the information necessary to complete the claim and will specify a reasonable time, no less than 48 hours, within which the claim must be completed. The Plan will decide the claim as soon as possible but not later than 48 hours after the earlier of (a) receipt of the specified information, or (b) the end of the period of time provided to submit the specified information.

If a pre-service or post-service claim is incomplete, the Plan may deny the claim or may take an extension of time, as described above. If the Plan takes an extension of time, the extension notice will include a description of the missing information and will specify a timeframe, no less than 45 days, in which the necessary information must be provided. The timeframe for deciding the claim will be suspended from the date the extension notice is received by the participant until the date the missing necessary information is provided to the Plan. If the requested information is provided, the Plan will decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

Appeals

A participant has the right to appeal any decision that denies payment of a claim or a request for coverage of a health care service or treatment.

Medical Appeals

If a participant believes that BCBSMS incorrectly denied all or part of a claim, he has the right to obtain a full and fair review. A request for a review must be made in writing to BCBSMS.

The participant has 180 days to request a review after receiving notice of denial from BCBSMS. The participant may provide additional information that relates to the denied claim. If the participant fails to request a review within this timeframe, the right to review is forfeited.

After the claim has been reviewed, if benefits are again denied, the decision will be sent to the participant in writing. The letter will include the reason(s) why benefits are denied, with reference to the Plan provisions on which the decision is based.

If, after following the appeal procedure described above, the participant still disagrees with the determination, a final internal appeal may be submitted in writing to the Department of Finance and Administration, Office of Insurance within 180 days after receiving the second denial from BCBSMS. The request to the Office of Insurance must include a copy of BCBSMS review decision and all information pertinent to the claim. The decision of the State Insurance Administrator with the Department of Finance and Administration, Office of Insurance is final and concludes all internal levels of appeal.

Within four months after the date of receipt of a final internal denial of a claim, the participant may file a request for an external review. An external review is available when the final denial involves an issue of medical necessity, appropriateness, health care setting, level of care, effectiveness, or rescission. The participant will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. The request must be made through the Office of Insurance and must include all information pertinent to the denied claim. An external review decision is binding on the participant except to the extent the participant has other remedies available under application federal or State law.

Failure to request a review within the above referenced time frames and in accordance with the procedures will result in the participant's right to an appeal and rights to sue being forfeited.

Prescription Drug Appeals
If a participant believes that Catalyst Rx incorrectly denied all or part of a prescription drug claim, he has the right to obtain a full and fair review. A request for review must be made in writing to Catalyst Rx.

The participant has 180 days from receiving notice of denial from Catalyst Rx to request a review. The participant may provide additional information that relates to the denied claim. If the participant fails to request a review within this timeframe, the right to review is forfeited.

After the claim has been reviewed, if benefits are again denied, the decision will be sent to the participant in writing. The letter will include the reason(s) why benefits are denied, with reference to the Plan provisions of which the decision is based.

If, after following the appeal procedure described above, the participant still disagrees with the determination, a final internal appeal may be submitted in writing to the Department of Finance and Administration, Office of Insurance within 180 days after receiving the second denial from Catalyst Rx. The request to the Office of Insurance must include a copy of the Catalyst Rx review decision and all information pertinent to the claim. The decision of the State Insurance Administrator with the Department of Finance and Administration, Office of Insurance is final and concludes all internal levels of appeal.

Within four months after the date of receipt of a final internal denial of a claim, the participant may file a request for an external review. An external review is available when the final denial involves an issue of medical necessity, appropriateness, health care setting, level of care, effectiveness, or rescission. The participant will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. The request must be made through the Office of Insurance and must include all information pertinent to the denied claim. An external review decision is binding on the participant except to the extent the participant has other remedies available under application federal or State law.

Failure to request a review within the above referenced time frame and in accordance with the procedures will result in the participant's right to an appeal and rights to sue being forfeited.

Utilization Review Appeals
If a participant or provider believes that ActiveHealth incorrectly denied all or part of a medical service, he may initiate the appeals process. The following chart outlines the process:

Step 1
The attending physician contacts ActiveHealth to discuss any findings of "not medically necessary" with the physician who initially made the determination. If the physician is not available, another physician will be made available. Based on that discussion, the ActiveHealth staff physician will determine whether the original decision should be affirmed or amended. The enrollee and attending physician will be notified in writing of the results of this review.

Step 2
The attending physician or participant may submit a request for appeal, outlining the reason for the request, within 180 days of the initial denial decision. A thorough review and discussion of medical records and other supporting documentation will be undertaken by a specialist with experience in the condition or procedure requested. Based on this review, a decision affirming or amending the original decision will be rendered and provided in writing to the enrollee and the attending physician. The physician may also request an expedited internal appeal at the same time as an expedited external review if the physician believes that the patient's life could be in jeopardy waiting the timeframe to complete a standard internal appeal.

Step 3
Within four months after the date of receipt of an adverse determination or a final internal denial of a claim, the participant may file a request for an external review. An external review is available when the final denial involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness. The participant will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. The request must be made through ActiveHealth. An external review decision is binding on the participant except to the extent the participant has other remedies available under application of Federal or State law.

Failure to request a review in accordance with the procedures above will result in the participant's right to an appeal and rights to sue being forfeited.

Out-of-network reviews are not subject to the utilization review appeals process. A denial of an out-of-network approval may be appealed directly to the Department of Finance and Administration, Office of Insurance.

Other Complaints
If a participant has a complaint regarding service provided by BCBSMS, Catalyst Rx, the AHS State Network, or ActiveHealth, he may write to the Office of Insurance. The letter should contain specific information about the complaint.

General Internal Appeals Process Information
The person who reviews and decides an appeal will be a different individual than the person who initially processed the claim. The review will take into account all information submitted by the participant, whether or not presented or available when the claim was processed. No deference will be given to the initial benefit decision.

In the case of a claim denied on the grounds of a medical judgment, the Plan will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the same individual who was consulted, if any, regarding the initial benefit decision or a subordinate of that individual.

A participant will, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. If the advice of a medical or vocational expert was obtained in connection with the initial benefit decision, the names of each such expert will be provided on request by the participant, regardless of whether the advice was relied on by the Plan.

The Plan will decide the appeal of a pre-service claim within a reasonable time appropriate to the medical circumstances but no later than thirty (30) days after receipt by the Plan of the appeal request (fifteen (15) days if there are two levels of internal appeals).

The Plan will decide the appeal of an urgent care claim as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt by the Plan of the appeal request. The Plan will decide the appeal of a post-service claim within a reasonable period but no later than sixty (60) days after receipt by the Plan of the appeal request (thirty (30) days if there are two levels of internal appeals).

Coordination of Benefits

If a participant is covered by another employer's benefit plan or another group type health benefit plan, there may be some duplication of benefit coverage between this Plan and the other plan. The Plan coordinates benefits with other plans to prevent duplication of payments for the same services. This section describes how Coordination of Benefits (COB) works under the Plan.

To determine how the plans coordinate benefits, one plan is considered "primary" and the other is considered "secondary". The primary plan pays benefits first, up to that plan's limits. The secondary plan will not pay benefits until the primary plan pays or denies a claim. In no instance will the primary and secondary plans pay, in total, more than the actual cost of the healthcare services.

If the other plan does not include a coordination of benefits or non-duplication provision, that plan will be primary.

The following are the provisions for determining which plan will be "primary":

Description	**Primary**	**Secondary**
Active Employee Note: If employee is covered as an "employee" under two plans, the plan covering the employee for the longest period of time is considered the primary plan.	State & School Employees' Health Insurance Plan	Other Health Plan
Dependent spouse with other coverage as "active employee"	Other Health Plan	State & School Employees' Health Insurance Plan
Active Employee & Spouse with children: both parents' health plans cover children	Follow birthday rule*	Follow birthday rule*
Active Employee, divorced or separated, both parents' health plans cover children with court order	Follow court decree	Follow court decree

*Under the birthday rule, the plan of the parent whose birthday falls earliest in the calendar year is the child's primary plan. If both parents have the same birthday, the parent who has been covered longer has the primary plan. If the other plan does not have the birthday rule, then the rule in the other plan will determine which is primary.

- If parents are divorced or separated and both parents' plans cover a dependent child, benefits for the child are determined in this order:
    - First, the plan of the parent with custody;

- Then, the plan of the stepparent (spouse of the parent with custody of the child); and
- Finally, the plan of the parent not having custody of the child**.**

Active/Inactive Employee: The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine which plan is primary.

Where the determination cannot be made in accordance with other provisions in this section, the plan that has covered the Plan participant for the longer period of time will be primary.

The term "plan" as used in this section means any of the following that provide benefits for services, for or by reason of, medical or dental care or treatment:

- Any health plan which provides services, supplies, or equipment for hospital, surgical, medical, or dental care or treatment, or prescription drug coverage, including, but not limited to, coverage under group or individual insurance policies, non-profit health service plans, health maintenance organizations, self-insured group plans, pre-payment plans, and Medicare as permitted by federal law. This does not include hospital daily indemnity plans, specified diseases-only policies, or limited occurrence policies that provide only for intensive care or coronary care in the hospital.
- Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under SCHIP Title XXI or Medicaid Title XIX (grants to States for Medical Assistance Programs of the United States Social Security Act as amended). It also does not include any law or plan when, by law, its benefits are in excess to those of any private insurance program or other non-governmental program.
- Any individual automobile no-fault insurance plan.
- Any labor-management trusted plan, union welfare plan, employer organization plan, or employee benefit organization plan.

Each plan or other arrangement for coverage outlined immediately above is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

For the purpose of this provision, BCBSMS may, without consent or notice to any person, release to or obtain from any insurance company or other organization or person any information that may be necessary regarding coverage, expenses, and benefits.

Participants claiming benefits under the Plan must furnish BCBSMS such information as may be necessary for the purpose of administering this provision.

Where any medical payment sums are applicable under any coverage, including but not limited to, automobile and premises liability policies, the limits of any such coverage must be applied to related claims before any benefits will be provided under this Plan.

Medicare Coordination

The Plan is the primary payer for an active employee, active employee's spouse, and active employee's dependent child that is also covered by Medicare.

Medicare is the primary payer for a retired employee, surviving spouse, or dependent of a retired employee or surviving spouse who is:

Age 65 or older.
Under age 65 with Social Security disability.
Under age 65 with end-stage renal disease after the first 30 months of Medicare eligibility.

If the participant does not elect Medicare Part A or B, benefits will be reduced as though Medicare is the primary payer. The Plan will calculate benefits assuming the participant has Medicare A and B.

A surviving spouse or dependent of a retired employee or surviving spouse age 65 or older is assumed to have Medicare Part A and B regardless of that participant's Medicare eligibility. The Plan will calculate benefits assuming the participant has Medicare A and B.

If a retiree is retroactively approved for Medicare due to Social Security disability, the Plan will update their records to reflect Medicare as the primary coverage effective the date of Medicare eligibility. The Plan will also refund any overpayment of premiums and reprocess claims to calculate benefits as secondary to Medicare.

Medicare Coordination – End-Stage Renal Disease

The Plan is the primary payer for:

- An active employee or employee's dependent spouse or child with end-stage renal disease during the first thirty (30) months of Medicare eligibility solely by reason of end-stage renal disease (Medicare is primary after the first 30 months).
- A retiree, surviving spouse, or retiree's or surviving spouse's dependent spouse or child under age 65 with end-stage renal disease during the first 30 months of Medicare eligibility.

Medicare is the primary payer for:

- An active employee or employee's dependent spouse or child with end-stage renal disease after the first 30 months of Medicare eligibility solely by reason of end-stage renal disease
- A retired employee, surviving spouse, or dependent of a retired employee or surviving spouse who is under age 65 with end-stage renal disease after the first 30 months of Medicare eligibility.

If the participant does not elect Medicare Part A, B, or D, benefits will be reduced as though Medicare is the primary payer. The Plan will calculate benefits assuming the participant has Medicare A, B, and D.

Refund of Overpayments and Subrogation

Refund to the Plan of Overpayment of Benefits
If Plan benefits are paid in error to any Plan participant or provider of service, the Plan reserves the right to have the overpayment refunded.

If any participant or provider of service does not promptly refund an overpayment to the Plan upon request, the Plan reserves the right to reduce any future benefit payments until the full amount of the overpayment is recovered.

Subrogation - Third Party Liability
As a condition to receiving medical benefits under the Plan, participants agree to transfer to the Plan their rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of another person. The Plan participant agrees to execute or cause to be executed any and all documents required by the Plan, including a Subrogation Reimbursement Agreement, and to execute or cause to be executed any documents on behalf of minor dependents covered by the Plan. In the event the dependent is a minor, Chancery Court approval of such Subrogation Reimbursement Agreement must be obtained prior to the payment of any benefits.

Alternatively, if a Plan participant receives any recovery, by way of judgment, settlement, or otherwise, from another person or business entity, the Plan participant agrees to reimburse the Plan in full, in first priority, for any medical expenses paid by it (i.e., the Plan shall be first reimbursed fully to the extent of any and all benefits paid by it from any monies received, with the balance, if any, retained by the Plan participant).

The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the settlement or judgment specifically designates the recovery, or a portion thereof, as including medical expenses.

The Plan's right of full recovery, either by way of subrogation or right of reimbursement, may be from funds the Plan participant or legal representative of the Plan participant receives or is entitled to receive from any third party or the insured's own uninsured/underinsured or medical payment motorist insurance.

The Plan may enforce reimbursement or subrogation rights by requiring the Plan participant or legal representative of the Plan participant to assert a claim to any of the foregoing coverage to which he may be entitled.

The Plan will not contribute to any attorney fees or costs associated with the Plan participant's recovery efforts.

In the event any hospital, medical, and related service or benefit is provided for, or any payment is made or credit is extended to a Plan participant for injuries or illnesses resulting from an act or omission of another party, the Plan will be subrogated and will succeed to the right of the Plan participant to recovery against any person, organization, or other carrier. The acceptance of such benefits hereunder will constitute such subrogation. The Plan participant must remit to the Department of Finance and Administration, for the Plan all sums recovered by suit, settlement, or otherwise, on account of such hospital, medical, and related service or benefit, and must take such action to furnish such information and assistance, and execute such assignments and other instruments as may be required to facilitate enforcement of rights hereunder, and must take no action prejudicing the rights and interest of the Department of Finance and Administration hereunder.

Failure by the Plan participant to execute such evidence of subrogation, as may be required, will make the Plan participant liable for all costs and expenses incurred under the Plan in his behalf because of such hospital, medical, and related services. Nothing contained in this provision will be deemed to change, modify, or vary the terms of the *Coordination of Benefits* section of this *Plan Document.*

Subrogation - Work Related

Benefits for work-related injuries or illnesses may be extended by the Plan where (1) liability is being controverted by the employer in a proceeding before the particular worker's compensation agency with jurisdiction and Plan participant's related claims are unpaid; or, (2) claims payments were made prior to notification to the Plan of their work-related nature.

Where the Plan does extend benefits for a work-related injury or illness, the Plan will be entitled to reimbursement where the employer acknowledges or the respective workers' compensation agency determines that the injury or illness is work-related. The Plan will be entitled to reimbursement even if a settlement does not specifically include payments for health care expenses. Reimbursement may be sought from the Plan participant or directly from the employer or its workers' compensation liability carrier. The Plan participant agrees to provide the Plan with prior notice of and opportunity to participate in any settlement proceedings.

The Plan participant will take such action, furnish such information and assistance, and execute such papers as the Plan may require to facilitate enforcement of its rights and will take no action prejudicing the rights and interest of the Plan.

The Plan participant must immediately notify the Plan of any injury, illness, or condition for which a claim has been or will be pursued under any applicable workers' compensation laws.

Health Plan Administration

The State and School Employees Health Insurance Management Board (Board) is the Plan Sponsor of the State and School Employees' Health Insurance Plan (Plan). The Board has the sole legal authority to promulgate rules and regulations governing the operations of the Plan within the confines of the law governing the Plan. The Department of Finance and Administration provides the day-to-day management of the Plan through the Office of Insurance.

The Board consists of the following members: the Executive Director of the Department of Finance and Administration, who serves as Chairman; the Chairman of the Workers' Compensation Commission; the Commissioner of Insurance; the Commissioner of Higher Education; the State Superintendent of Education; the State Personnel Director; the Executive Director of the Mississippi Community College Board; the Executive Director of the Public Employees' Retirement System; two (2) appointees of the Governor whose terms are concurrent with that of the Governor, one (1) of whom has experience in providing actuarial advice to companies that provide health insurance to large groups and one (1) of whom has experience in the day-to-day management and administration of a large self-funded health insurance group; the Chairman of the Senate Insurance Committee or his designee; the Chairman of the House of Representatives Insurance Committee or his designee; the Chairman of the Senate Appropriations Committee or his designee; the Chairman of the House of Representatives Appropriations Committee or his designee. The legislators, or their designees, serve as ex officio, nonvoting members of the Board.

The Board selects, through a comprehensive request for proposals process, all vendors who provide services under the Plan. These services include claims administration, pharmacy benefits management, provider network administration, utilization management, wellness and health promotion, data management, and actuarial and consulting services.

Notice of Election of Exemption From Certain Requirements of the Health Insurance Portability and Accountability Act (HIPAA)

Name of Plan: State and School Employees' Life and Health Insurance Plan

Plan Sponsor: State and School Employees Health Insurance Management Board
c/o Department of Finance and Administration
P.O. Box 24208
Jackson, MS 39225-4208

Plan Year January 1, 2012 through December 31, 2012

Notice to Participants:

Federal law imposes upon group health insurance plans the following requirements from which a self-funded non-federal governmental plan may elect to be exempted in whole or in part:

(1) Standards relating to benefits for mothers and newborns;
(2) Parity in the application of certain limits to mental health benefits; and
(3) Required coverage for reconstructive surgery following mastectomies.

The State and School Employees Health Insurance Management Board has elected to exempt the State and School Employees' Life and Health Insurance Plan, as a non-federal governmental plan, from these requirements in their entirety. The Board, however, has elected to generally comply with the intent of these requirements voluntarily. The necessary changes to Plan benefits have been implemented and are included in this *Plan Document*.

Federal law also requires the Plan to provide covered participants with a certificate of creditable coverage when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that a participant was covered under this Plan, because establishing prior coverage may entitle a person to certain rights when joining another employer's health plan or if the participant wishes to purchase an individual health insurance policy.

General Conditions

Covered Expense
Covered expense is incurred on the date the service is received or rendered.

Benefits for covered expenses will be provided only to the extent that the provider can render such service, and payment therefore to the provider by BCBSMS or Catalyst Rx as herein provided will constitute a complete discharge of the obligation of the Plan hereunder.

The Plan does not insure against any condition, disease, ailment, or injury (including pregnancy and conditions arising from it), but only provides benefits for covered expenses incurred by a Plan participant during his effective dates of coverage under the Plan.

Liability
Neither the Plan Sponsor nor its contractors, their agents, or their employees will be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance, or malpractice on the part of any hospital or other institution, any agent, or employee thereof, or on the part of any physician, health care professional, pharmacist, or other person participating in or having to do with the care or treatment of the Plan participant.

Notices
Any notice required to be given by a contractor of the Plan Sponsor to an enrollee hereunder will be deemed to be given and delivered when deposited in the United States mail, postage prepaid, addressed to the enrollee at his address as the same appears on the records of BCBSMS.

Proof of Loss
Upon failure of the Plan participant to notify BCBSMS or Catalyst Rx or furnish proof of loss, payment may be refused or a percentage of the regular payment may be paid at the option of the Plan; provided, however, failure to give notice of proof of loss within the time provided will not invalidate a claim if it can be shown that compliance with this provision was not reasonably possible and that notice of claim was given as soon as reasonably possible.

Breach or Default
Whenever any condition or requirement of the Plan has been breached by the Plan participant or he is in default as to any term or condition hereof, failure of the Plan Sponsor, BCBSMS, ActiveHealth, Catalyst Rx, or WebMD to avail of any right stemming from such breach or default, or indulgences granted, will not be construed as a waiver of the right of the Plan Sponsor, BCBSMS, ActiveHealth, or Catalyst Rx on account of existing or subsequent such breach or default.

Network Agreements
The Network has entered into payment agreements with participating hospitals to provide services to Plan participants. Under these payment agreements, the Plan does not always pay an amount to the hospital which corresponds to the amount indicated on the Explanation of Benefits.

The Pharmacy Benefit Manager has developed a Clinical Drug Formulary (Formulary) and list of preferred drugs. The list of preferred drugs is a subset to the Formulary, which serves as a guideline for the most commonly prescribed medications. The use of the Formulary may generate savings from drug manufacturers. These savings are generated from prescription drug claims. Any savings as a result of the Formulary are utilized in the financing of the Plan.

Terms
The terms "pay", "paid", "payment", and "payable", as well as similar terms, are found throughout this *Plan Document*. When the aforementioned terms are used with respect to the provision of benefits, the terms are referencing the benefits provided under the Plan, rather than the actual amount paid by the Plan.

Disclosure
The State and School Employees' Health Insurance Plan may disclose summary health information to the Plan Sponsor for the administrative functions of the Plan to include payment, treatment, and operations as defined by the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. Parts 160-64).

Privacy of Protected Health Information
The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as updated under the American Recovery and Reinvestment Act ("ARRA") gives participants certain rights and imposes certain obligations on the Plan with respect to health information. The following sections describe protections afforded a participant's health information as it relates to coverage under the Plan. This information is referred to as "protected health information."

The State and School Employees Health Insurance Management Board is the Plan Sponsor. The Plan will disclose protected health information to the Plan Sponsor only upon receipt of certification by the Plan Sponsor that the *Plan Document* has been amended to incorporate the following provisions. The Plan Sponsor agrees to abide by the following requirements:

(a) The Plan Sponsor will use or disclose protected health information only to carry out Plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. Parts 160-64), updated in the American Recovery and Reinvestment Act as permitted or required by the *Plan Document* or as required by law.

(b) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides protected health information agrees to the same restrictions and conditions included in the *Plan Document* with respect to protected health information.

(c) The Plan Sponsor will not use or disclose protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(d) The Plan Sponsor will report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures allowed under the *Plan Document* of which it becomes aware.

(e) The Plan Sponsor will make any protected health information solely available to it available in accordance with 45 Code of Federal Regulations § 164.524.

(f) The Plan Sponsor will make protected health information solely available to it for amendment in accordance with 45 Code of Federal Regulations § 164.526.

(g) The Plan Sponsor will track disclosures it may make of protected health information solely available to it so that it can make available the information required for the Plan or its business associates to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.

(h) If the Plan Sponsor uses or maintains electronic health records with respect to PHI, if requested, the Plan Sponsor will provide a copy of such information in "electronic format".

(i) The Plan Sponsor will make available its internal practices, books, and records, relating to its use and disclosure of protected health information, if any, to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.

(j) The Plan Sponsor will, if feasible, return or destroy all protected health information in any form received from the Plan, when protected health information is no longer needed for the Plan administration purposes for which the disclosure was made. If it is not feasible to return or destroy all such protected health information, the Plan Sponsor will limit the use or disclosure of any protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

The following employees or classes of employees or other workforce members under the control of the Plan Sponsor may be given access to protected health information received from the Plan or a health insurance issuer or business associate servicing the Plan:

Employees of the Department of Finance and Administration, Office of Insurance.

(a) This list includes every employee or class of employees or other workforce members under the control of the Plan Sponsor who may receive protected health information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

(b) The employees, classes of employees, or other workforce members identified above will have access to protected health information only to perform the Plan administration functions that the Plan Sponsor provides for the Plan.

(c) The employees, classes of employees, or other workforce members identified above will be subject to disciplinary action and sanctions, including if appropriate, termination of employment or affiliation with Plan Sponsor, for any use or disclosure of protected health information in non-compliance with the provisions of the *Plan Document*. The Plan Sponsor will impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the non-compliance and will work to mitigate any deleterious effect of the non-compliance on any participant or beneficiary.

Security of Electronic Protected Health Information

HIPAA also imposes certain obligations on the Plan Sponsor to secure protected health information when it is in an electronic format (called "ePHI"). In order for the Plan to disclose any ePHI to the Plan Sponsor, the Plan Sponsor must amend the Plan Document to incorporate certain provisions required under HIPAA. The Plan Sponsor hereby amends the Plan Document and agrees to be bound by the following requirements:

(a) The Plan Sponsor implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that it creates, receives, maintains, or transmits on behalf of the Plan in accordance with 45 C.F.R. Parts 160, 162, and 164.

(b) The Plan Sponsor will make certain that the HIPAA privacy requirements, applicable to its employees and other workforce members under the control of the Plan Sponsor who are not allowed access to ePHI as part of their role in performing Plan administrative functions, are also supported by reasonable and appropriate security measures.

(c) The Plan Sponsor will make certain that any third party administrators or other entities providing services to the Plan (called business associates) and their subcontractors agree to implement reasonable and appropriate security measures to safeguard the ePHI in their possession or control.

(d) The Plan Sponsor will report any incident involving the security of ePHI to the Plan's Security Official as soon as reasonably possible.

(e) In the event of a breach of "unsecured" PHI, the Plan Sponsor will provide notification of the breach of unsecured PHI without unreasonable delay, and in no case later than 60 days, after discovery of the breach. Unsecured PHI is defined as PHI that is not secured using Secretary of Health and Human Services-approved standards.

Glossary

Accidental Injury: a sudden and unforeseen event from an external agent or trauma, resulting in injuries to the physical structure of the body. It is definite as to time and place and it happened involuntarily or, if the result of a voluntary act, entails unforeseen consequences.

Acute Care: short-term diagnostic and therapeutic services provided in a hospital for a patient who is ill from a disease or injury of an acute nature. The period of acute care continues until the patient is stable enough to be transferred to a long-term care facility or bed for rehabilitation or maintenance care or until the patient can be discharged to home care.

Allowable Charge: the lesser of the submitted charge or the amount established by the Plan as the maximum amount allowed for covered expenses. The allowable charge is subject to change.

Ambulatory Surgical Facility: an institution licensed as such by the appropriate state agency or certified by Medicare as an Ambulatory Surgical Facility whose primary purpose is performing elective or non-emergency surgical procedures on an outpatient basis and is approved by the Claims Administrator.

Brand Name Drug: A drug with a trademark name protected by a patent issued to the original innovator or marketer. The patent prohibits the manufacture of the drug by other companies without consent of the innovator, as long as the patent remains in effect.

Calendar Year: a twelve (12) month period beginning each January 1.

Certificate of Creditable Coverage: certificate provided by a prior health insurance carrier showing dates of creditable coverage as defined by HIPAA.

Certification: a review by ActiveHealth to determine if an admission or healthcare service is medically necessary as well as meets the notification requirements of the Plan.

Child: any natural child, stepchild, child placed in anticipation of adoption, legally adopted child, child for whom the enrollee is legal guardian, child for whom the enrollee has legal custody, or child of the enrollee who is required to be covered by reason of a Qualified Medical Child Support Order.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986): Federal regulations that provide participants the option to pay for continued coverage under the Plan in the event that the participant no longer meets the Plan eligibility requirements.

COBRA Participant: a qualified beneficiary who elects to continue coverage under the Plan due to a qualifying event.

Coinsurance: the amount of an allowable charge (usually a percentage) that a participant pays for covered expenses after the appropriate deductible is met.

Coinsurance Maximum: the amount indicated in the Select Coverage *Summary of Benefits* in unreimbursed expenses for covered expenses a participant incurs in a calendar year, after which benefits are paid at 100% of the allowable charge for the remainder of the calendar year. Certain expenses cannot be used to meet the coinsurance maximum.

Coinsurance/Co-payment Maximum: the amount indicated in the Base Coverage Summary of Benefits in unreimbursed expenses for covered expenses a participant incurs in a calendar year, after which benefits are paid at 100% of the allowable charge for the remainder of the calendar year. Certain expenses cannot be used to the meet the coinsurance/co-payment maximum.

Convalescent Facility: An institution (or distinct part thereof), which meets each of the following tests:

- It is primarily engaged in and licensed to provide, for compensation, skilled nursing services or intermediate care services and physical restoration services to convalescing patients on an inpatient basis.
- It provides these services on a twenty-four (24) hour daily basis and under the full-time supervision of a physician or a registered nurse, with licensed nursing personnel on duty at all times.
- It maintains a complete medical record on each patient and has a utilization review plan for all of its patients.
- It is not, other than incidentally, a place for rest, custodial care, educational care, the care of mental disorders, or a place for the aged. Mental disorders include, but are not limited to, drug addiction, alcoholism, chronic brain syndrome, and mental retardation.

Skilled nursing services and intermediate care services means services rendered by a registered nurse or by a licensed practical nurse under the direction of a registered nurse; physical restoration services means services which assist the patient to achieve a sufficient degree of body functioning to permit self-care in the essential activities of daily living; custodial care means care primarily to aid the patient with bathing, dressing, eating, and other activities of daily living; and, chronic brain syndrome means a condition of mental deterioration involving some irreversible brain damage due to a variety of causes ranging from alcohol abuse to senile dementia of unknown cause.

Coordination of Benefits (COB): the process that determines the order of benefits payable when an enrollee and/or his eligible dependent(s) are covered under more than one insurance plan.

Co-payment: the amount of an allowable charge (usually a flat fee) that a participant pays for a covered expense after the appropriate deductible is met.

Covered Expense: the expense incurred for eligible services, supplies, and prescription drugs subject to the allowable charge, received on or after the effective date of the participant's coverage. The expense incurred, or portion of such expense, for medical care, services, supplies, or prescription drugs that are prescribed by a health care professional and are necessary in conjunction with the therapeutic treatment of the injury or illness involved, are not excluded from payment of benefits by the provisions of a particular coverage or by the exclusions and limitations, and are not in excess of the allowable charges for the same or similar medical care, services, supplies, or prescription drugs.

Covered Provider or Provider: health care professionals or facilities (as defined in this *Plan Document*) providing services within the scope of their license under state law. No other practitioners are considered covered providers.

Creditable Coverage: prior health insurance coverage as defined by HIPAA used to reduce the length of a pre-existing condition exclusion period.

Custodial Care: services and supplies furnished primarily to assist an individual in the activities of daily living, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care, or supervisory care by a physician for a participant who is mentally or physically disabled. Such services and supplies are custodial care without regard to whom they are prescribed, by whom they are recommended, or by whom or by which they are performed. This term also includes convalescent or domiciliary care.

Deductibles (Base Coverage):

Individual Calendar Year Deductible: a specific dollar amount that a participant must meet for covered expenses before the Plan will pay benefits in a calendar year.

Family Calendar Year Deductible: a cumulative dollar amount that, when met, satisfies the calendar year deductible for covered expenses for all family members.

Deductibles (Select Coverage):

Calendar Year Deductible: a specific dollar amount that a participant must meet for covered medical expenses before the Plan will pay benefits in a calendar year.

Family Deductible: a cumulative dollar amount that, when met, satisfies the calendar year deductible for covered medical expenses for all family members.

Prescription Drug Deductible: a specific dollar amount that a participant must meet for covered prescription drugs before the co-payment amount is applied in a calendar year.

Disabled dependent: a child who is:

- Unmarried,
- Permanently mentally or physically disabled or incapacitated,

- So incapacitated as to be incapable of self-sustaining employment,
- Dependent upon the enrollee for 50% or more support, and
- Otherwise eligible for coverage as a dependent except for age.

The disabling condition must have occurred prior to the dependent's 26th birthday.

Durable Medical Equipment: equipment prescribed by the attending physician and determined by BCBSMS to be medically necessary for treatment of an illness or injury, or to prevent the participant's further deterioration. The equipment must be (1) made to withstand repeated use; (2) primarily used to serve a medical purpose rather than for comfort or convenience; (3) generally not useful to a person in the absence of illness, injury, or disease; and (4) appropriate for use in the participant's home.

Emergency Care: care as the result of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical care could reasonably result in:

- Permanently placing the participant's health in jeopardy,
- Serious impairment of bodily functions, or
- Serious and permanent dysfunction of any bodily organ or part, or other serious medical consequences.

Determination of emergency care is based on presenting symptoms rather than final diagnosis. This means the treatment given in a hospital's or urgent care's emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction to a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the mother or fetus.

Employee: an active full-time employee who has satisfied the specifications in the *Health Insurance Eligibility and Enrollment* section of this *Plan Document*.

Employer Unit: any of the following whose employees are eligible to participate in the Plan:

- State Agency,
- Institution of Higher Learning,
- Public School District,
- Community/Junior College, or
- Public Library.

Enrollee: an Employee, a Retired Employee, a COBRA Participant, or a Surviving Spouse who is enrolled in the Plan.

Explanation of Benefits (EOB): an itemized statement from BCBSMS or Catalyst Rx that lists charges made and the benefits allowed or denied as the result of a claim.

Facility: a hospital or other entity licensed or certified by the appropriate state or federal agency and approved by the Plan and BCBSMS as a specific type of institution to provide a specific level of care.

Formulary: A specific list of drugs maintained by Catalyst Rx, which can assist practitioners and pharmacies in selecting clinically appropriate and cost-effective drugs. The formulary represents the clinical judgment of physicians, pharmacists, and other experts in the diagnosis and/or treatment of disease and promotion of health.

Generic Drug: a drug that is therapeutically equivalent (identical in strength, concentration, and dosage form) to a brand-name drug and that generally is made available after the expiration of the brand name patent.

Health Care Professional: a physician or other medical practitioner who is licensed to perform specified health services consistent with state law. For the Plan, health care professionals also include:

- Physical therapists,
- Occupational therapists,
- Speech pathologists,
- Clinical psychologists (doctoral level),
- Professional counselors,
- Clinical social workers, and
- Marriage and Family Therapists.

Health Savings Account (HSA): portable, interest-bearing, funded accounts to provide for tax-free savings for medical expenses as provided by Section 1201 of the Medicare Prescription Drug Improvement and Modernization Act of 2003.

HIPAA: the Health Insurance Portability and Accountability Act of 1996, including all amendments.

Home Infusion Therapy: services and supplies required for the administration of home infusion therapy regimen.

Horizon Employee: An employee initially hired on or after January 1, 2006, who has never been a full-time employee of a Mississippi State agency, public school district, community/junior college, public library, or university.

Hospice Care: A program in which emphasis is placed upon palliative and supportive care, either on an inpatient or outpatient basis, to meet the special needs of patients and their families during the final stages of illness. Full scope health services are provided by an organized interdisciplinary team, available on a 24-hour-a-day, 7-days-a-week basis.

Hospital: an institution which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of physicians who are duly licensed to practice medicine in the state where the institution is located; which continuously provides 24-hour a day nursing service by a Registered Nurse (RN); and which is duly licensed as a hospital in such state. The term hospital may also include an institution that primarily provides psychiatric or chemical dependency care, if licensed as such by the state in which the hospital is located. Benefits are not provided for treatment in a facility that is primarily a place for rest, rehabilitation, or the aged, including custodial and convalescent, except as otherwise provided by the Plan.

Illness: an accidental injury, a bodily or mental disorder, a pregnancy, or any birth defect of a newborn child. Conditions that exist and are treated at the same time or are due to the same or related causes are considered to be one illness.

Intensified Outpatient Program: as provided for the treatment of substance abuse, intensified outpatient program refers to a program provided as a continuation of inpatient substance abuse treatment prescribed by a physician, under the management of a substance abuse provider, which is licensed or certified by the appropriate state or federal agency and is approved by the Plan.

Investigative or Experimental: use of a procedure, facility, equipment, drug, device, or supply not recognized at the time of treatment as accepted medical practice within the United States for the condition being treated. A drug, device, medical treatment, or procedure will be determined to be experimental or investigational if:

- there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- it cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) or other governmental agency and such approval has not been granted at the time of its use or proposed use; or
- it is the subject of a current investigational new drug or new device application on file with the FDA; or
- a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
- a written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.
- It is being provided pursuant to:

- A Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial; or
- A written protocol which describes among its objectives, determinations of safety, toxicity, effectiveness, or effectiveness in comparison to conventional alternatives; or
- Is being delivered, or should be delivered, subject to the approval and supervision of an Institutional Review Board (IRE) as required and defined by federal regulations particularly those of the FDA or the Department of Health and Human Services (HHS), or

In the predominant opinion among experts:

- As expressed in the published, authoritative literature, is substantially confined to use in research setting; or
- Is subject to further research in order to define safety, toxicity, effectiveness, or effectiveness compared with conventional alternatives; or
- Is experimental, investigational, unproven, or is not a generally acceptable medical practice; or
- Is not a covered service under Medicare because it is considered investigational or experimental as determined by the Centers for Medicare and Medicaid (CMS) of HHS; or
- Is provided concomitantly to a treatment, procedure, device, or drug which is experimental, investigational, or unproven treatment.

The Plan may, at its discretion, determine that a drug, device, medical treatment, or procedure, which is deemed experimental or investigational under the above criteria, should nonetheless not be deemed experimental or investigational.

Legacy Employee: An employee who is an active employee as of January 1, 2006, or an employee hired on or after January 1, 2006, who was ever a full-time employee with a Mississippi State agency, public school district, community/junior college, public library, or university prior to January 1, 2006.

Legal Custody: the permanent legal status created by a court order which gives the legal custodian the responsibilities of physical possession of the child and the duty to provide him with food, shelter, education, and reasonable medical care.

Legal Custodian: a court appointed custodian of a child.

Legal Guardian: a court appointed guardian of a child.

Legal Guardianship: the permanent legal status created by a court order which gives the guardian of a child the same responsibilities as though he was the child's natural parent. This includes the duty to feed, clothe, house the child, and make decisions concerning the child's education and health care.

Long Term Acute Care Facility: A facility specializing in treating patients with serious and often complex medical conditions requiring a longer length of stay than is usually provided by traditional acute care hospitals.

Maintenance Drug: a prescription drug taken for an extended period of time for a chronic health condition.

Manipulative Therapy: all services preparatory to or complementary to an adjustment of the articulations of the vertebral column and its immediate articulations.

Medical Claims Administrator: the organization under contract with the Health Insurance Management Board to maintain eligibility and process medical claims for the Plan. The Medical Claims Administrator for the Plan is Blue Cross & Blue Shield of Mississippi (BCBSMS).

Medical Management Administrator: the organization under contract with the State and School Employees Health Insurance Management Board to provide inpatient and outpatient utilization review and case management services. The Medical Management Administrator for the Plan is ActiveHealth.

Medical Supplies or **Supplies**: supplies which are medically necessary disposable items, primarily serving a medical purpose, (and generally not useful to a person in the absence of illness, injury, or disease) having therapeutic or diagnostic characteristics essential in enabling a participant to effectively carry out a physician's prescribed treatment for illness, injury, or disease, and are appropriate for use in the participant's home.

Medically Necessary: A service or supply furnished by a particular provider is medically necessary if it is determined by the Plan that it is appropriate for the diagnosis, the care, or the treatment of the disease or injury involved. To be appropriate, the service or supply must:

- Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- As to diagnosis, care, and treatment, be no more costly (taking into account all health expense incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, the following will be taken into consideration:

- Information provided on the affected person's health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and

- Any other relevant information.

In no event will the following services or supplies be considered to be medically necessary:

- Those that do not require the technical skills of a medical, a mental health, or a dental professional; or
- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider, or healthcare facility; or
- Those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's office or other less costly setting.

Medically necessary services or supplies must be:

- Prescribed by a physician to be necessary and appropriate;
- Non-experimental or non-investigational;
- Not in conflict with accepted medical or surgical practices prevailing in the geographic area where, and at the time when, the service or supply is ordered;
- Not associated with an occupational injury or disease; and
- Reasonable.

Medical necessity does not include any service or supply that is for the psychological support, education, or vocational training of the participant. Medical necessity does not include implant of any artificial organ for any reason whatsoever.

Network: A group of providers under contract with the Network Administrator to participate in the Plan's AHS State Network.

Network Administrator: the organization under contract with the State and School Employees Health Insurance Management Board, which contracts with covered providers to provide negotiated discounts in a defined geographic area. The Network Administrator is responsible for the selection of and ongoing contracting with covered providers. The Network Administrator for the Plan is the Advanced Health Systems (AHS).

Non-occupational Injury or Disease: an injury or disease that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury or disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law, and
- Is not covered for that disease under such law.

Non-participating Pharmacy: a pharmacy that has not contracted with the Pharmacy Benefit Manager to be a participating provider of prescription drugs to Plan participants.

Non-participating Provider: a covered provider who has not contracted with the AHS State Network to deliver covered medical services or supplies to Plan participants.

Orthotic Device: an orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body.

Out-of-Area Participant: a Plan participant whose principal/primary residence is located outside the geographic boundaries of the State of Mississippi. Dependent children between the ages of 19 and 26 are not considered out-of-area participants.

Out-of-Network Review: the process by which ActiveHealth determines if the Plan will allow in-network level benefits for services provided by a non-participating provider.

Partial Hospitalization: inpatient psychiatric treatment, other than full twenty-four hour programs, in a treatment facility licensed or certified by the state in which services are rendered. The term includes day, night, and weekend treatment programs.

Participant or Plan Participant: an individual who is enrolled in the Plan and is eligible to receive health care services for which payment may be sought under the terms of this *Plan Document*.

Participating Pharmacy: a pharmacy that has a contractual relationship with the Pharmacy Benefit Manager to provide prescription drugs to Plan participants.

Participating Provider: a covered provider that has a contractual relationship with the AHS State Network to deliver covered services and supplies to participants.

PERS: the Public Employees' Retirement System of Mississippi.

Pharmacy Benefit Manager: the organization under contract with the State and School Employees Health Insurance Management Board to administer the prescription drug program. The Pharmacy Benefit Manager for the Plan is Catalyst Rx.

Physician: A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is legally qualified and licensed to practice medicine at the time and place service is rendered. A Doctor of Dental Surgery (D.D.S.), Doctor of Surgical Chiropody (D.S.C.), Doctor of Podiatry (D.P.M. of Pod. D.), Optometrist (O.D.), Chiropractor (D.C.), Certified Registered Nurse Anesthetist (CRNA), Physician Assistant (PA), or Nurse Practitioner (N.P.), when duly licensed and practicing within the scope of his license, is deemed to be a physician for purposes of this *Plan Document*.

Plan: the self-insured Plan administered by the State and School Employees Health Insurance Management Board consisting of the Mississippi State and School Employees' Life and Health Insurance Plan as defined in § 25-15-1 et seq. of the Mississippi Code.

Plan Document: the statement of terms and conditions of the Plan as adopted by the Plan Sponsor.

Plan Sponsor: the State and School Employees Health Insurance Management Board, acting administratively through the Department of Finance and Administration, Office of Insurance.

Pre-existing Condition: any condition for which medical advice, diagnosis, care, treatment, consultation, or a prescription drug was recommended or received within six (6) months prior to the Plan participant's effective date with the Plan. Medical condition or condition means any physical or mental condition resulting from illness, injury, or congenital malformation. However, genetic information is not a condition. Benefits are not provided under this Plan for any pre-existing condition until coverage in this Plan has been in effect for a period of 12 consecutive months (or 18 months for late entrants). The pre-existing condition exclusion does not apply to pregnancy. The pre-existing condition exclusion does not apply to dependent children under age 19. The exclusion period will be reduced by the amount of prior creditable coverage that the participant has when coverage becomes effective.

Prescription Drug: drugs that under Federal Law may be dispensed only by written prescription and that the Food and Drug Administration has approved for general use. Prescription drugs must be dispensed by a licensed pharmacist upon the prescription order from a licensed prescriber, usually a physician, must be medically necessary, must not be experimental/investigative, and must not otherwise be excluded in order to be covered under the Plan.

Proof of Loss: written evidence of expenses incurred or payable for services or supplies covered under the terms of this Plan.

Prosthetic Device: an artificial device that replaces all or part of an absent body part, or replaces all or part of the function of a permanently inoperable or malfunctioning body part.

Rehabilitative Care: coordinated use of medical, social, educational, or vocational services, beyond the acute care stage of disease or injury, for the purpose of upgrading the physical and functional ability of a patient disabled by disease or injury so that the patient may independently carry out ordinary daily activities.

Residential Facility: a licensed facility providing an inpatient rehabilitation program for the treatment of alcohol or drug abuse or mental or nervous conditions.

Retired Employee: a covered employee who has left employment and qualifies for retirement benefits under a retirement plan approved by the Mississippi Public Employees' Retirement System (PERS).

Skilled Nursing Facility: a health institution planned, organized, operated, and maintained to provide facilities and health services with related social care to inpatients requiring medical care and 24-hour nursing services for illness, injury, or disability. Each patient shall be under the care of a licensed physician. The nursing services shall be organized and maintained to provide 24-hour nursing services under direction of a registered professional nurse employed full-time.

Surviving Spouse: the covered spouse of a deceased employee who was eligible to retire or the covered spouse of a deceased retiree who was covered under the Plan at death.

Utilization Review: evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities.

Valid Assignment: an assignment of benefits to participating providers or to a covered provider that has not been offered an agreement to participate in the Plan's network.

Wellness and Health Promotion Vendor: the organization under contract with the State and School Employees Health Insurance Management Board to provide wellness and health promotion services. The Wellness and Health Promotion Vendor for the Plan is WebMD Health Services.

Group Term Life Insurance

The Health Insurance Management Board is authorized by state law to provide certain specified group life insurance benefits for active employees and retirees. The Board currently contracts for a fully insured group term life insurance policy with Minnesota Life Insurance Company (Minnesota Life) to provide a fully insured group term life insurance policy for eligible employees and retirees of State agencies, universities, public libraries, and certain community/junior colleges and public school districts. Those community/junior colleges and public school districts that are not covered under the Board's policy with Minnesota Life have elected to opt out of the State and School Employees' Life Insurance Plan and instead purchase similar coverage through an alternative policy from a private carrier. The following information pertains primarily to coverage under the Minnesota Life contractual policy between the Board and Minnesota Life in the State and School Employees' Life Insurance Plan only. Questions relative to the aforementioned alternative policy should be directed to the respective community/junior college or public school district, or to the private carrier.

The State of Mississippi offers group term life insurance coverage for active full-time employees. Life insurance coverage can be continued when a covered employee retires or becomes totally disabled (as determined by Minnesota Life). The following is a summary of the pertinent information relative to the State and School Employees' Life Insurance Plan. Participants should refer to the *Your Group Plan* booklet for a comprehensive description of the benefits and policy provisions. The *Your Group Plan* booklet may be accessed on the Plan's website at http://knowyourbenefits.dfa.state.ms.us. Active employees who do not have access to the internet should contact their employer for a paper copy of the *Your Group Plan* life insurance summary of coverage booklet, while participating retirees and totally disabled employees without internet access should contact the Department of Finance and Administration, Office of Insurance for a booklet.

At a Glance…

Minnesota Life Insurance Company	Minnesota Life is the insurer for the State and School Employees' Life Insurance Plan.
Amount of Life Insurance	• Active Employees: the amount of life insurance is equal to 2 times the annual salary, raised to the next higher thousand. Minimum - $30,000, maximum - $100,000. • Retirees may continue their term life insurance coverage at a reduced benefit level of $5,000, $10,000, or $20,000. Participating employees who retired prior to 7/1/1999 are limited to benefit levels of $2,000, $4,000, or $10,000. • Totally disabled employees approved for continued coverage by Minnesota Life can continue group term life insurance coverage with the same amount of term life insurance coverage they had as an active employee. Dependents are not eligible for life insurance coverage under the Plan.

Cost Sharing	An active employee and the State of Mississippi share equally in the cost of the monthly premium for life insurance. A retiree is solely responsible for paying his monthly premium. A totally disabled employee pays an initial nine-month's premium, after which the premium is waived to age 65, subject to continuation of his disability.
Accidental Death & Dismemberment	The policy also provides accidental death and loss of use coverage to active employees at no additional cost.
Conversion	A covered active employee may convert some or all of his life insurance coverage to an individual policy with Minnesota Life after leaving State employment. This provision also includes coverage amounts lost or reduced due to retirement.
Blue Cross & Blue Shield of Mississippi (BCBSMS)	BCBSMS maintains life insurance coverage information and administers the premium billing.
Filing a Claim	Claims for active employee coverage should be filed initially with the employee's personnel office. Claims for retiree and/or totally disabled employee coverage should be filed directly with the Mississippi Department of Finance and Administration's Office of Insurance.

Who Is Eligible?
The following persons are eligible for group term life insurance coverage:

- **A full-time employee who:**
  - receives compensation directly from one of the following Mississippi public entities:
    - ◊ department, agency, or institution of State Government,
    - ◊ public school district,
    - ◊ community /junior college,
    - ◊ institution of higher learning, or
    - ◊ public library
  - works for the State's judicial branch, or
  - works for the State's legislative branch, or
  - works as a full-time salaried Judge, or
  - works as a full-time salaried District Attorney, or is a member of his staff, or
  - works as a full-time compulsory school attendance officer, or
  - works for a university based program authorized under state law for deaf, aphasic, and emotionally disturbed children.
- **A regular non-student school bus driver.**
- **A retired employee (must have had coverage in the Plan as an active employee and must make timely application and pay appropriate premiums to continue coverage).**

Enrolling in Life Insurance
An eligible employee must either enroll in life insurance coverage or waive coverage when he begins covered employment. If the employee enrolls in the life insurance coverage, the effective date of coverage is his date of employment; however, a life insurance ***Enrollment/Change Request Form*** **must be completed, signed, and sent to the employer within the first 31 days of employment.**

Late Enrollees
If an employee applies for life insurance after the first 31 days of employment or initially waives coverage when first eligible and subsequently elects to participate, he will be considered a "late enrollee" applicant. As a late enrollee, he will be required to complete an *Evidence of Insurability Statement* in addition to the life insurance *Enrollment/Change Request Form*. Forms can be found on the Plan's website at http://knowyourbenefits.dfa.state.ms.us or are available from the employee's personnel office. The employee must return the *Enrollment/Change Request Form* to his employer. The employee may submit the completed *Evidence of Insurability Statement* confidentially directly to Minnesota Life or return the form to his employer for submission. Minnesota Life will be responsible for evaluating the late enrollment request, along with any follow-up documentation they may request from the applicant to determine if coverage will be approved. Upon completion of their review and determination process, Minnesota Life will notify the employee and the employer of their decision. Minnesota Life is the sole authority for evaluating late enrollment applications.

If a late enrollee application is approved, the effective date of coverage will be the first of the month following or coincident with the date of Minnesota Life's approval.

How Much Coverage Can An Employee Have?
An employee's life insurance amount is calculated by doubling his annual salary and rounding the result up to the next higher thousand.

The minimum amount of life insurance under the Plan for employees is $30,000, and the maximum amount is $100,000, regardless of annual salary.

If an employee's salary changes (increases or decreases), the amount of life insurance coverage may also change. Any change in the amount of the employee's life insurance will be effective on the first day of the month following or coincident with the change in salary.

Cost of Coverage for Employees
The employee shares with his employer in the cost of his life insurance premiums. The employee pays half of the monthly premium cost through payroll deduction, and his employer pays the other half.

Accidental Death and Dismemberment Benefits

The group term life insurance coverage provides an accidental death and dismemberment and loss of use (AD&D) benefit to covered employees at no additional cost. The amount of the AD&D benefit is based on the employee's term life insurance amount, and varies depending upon the specific loss. Refer to the *Your Group Plan* booklet for a complete schedule of AD&D benefits. AD&D benefits may be paid for losses due to an accidental bodily injury while insured. In other words, AD&D benefits are generally available when death or a covered bodily injury is the direct result of an accident and independent of all other causes. AD&D coverage is provided to an employee so long as he maintains his term life insurance coverage. Totally disabled employees and retirees are not eligible for AD&D coverage.

Retiring Employees

A retiring employee must be participating in the life insurance plan as an active employee at the time of his retirement in order to continue coverage as a retiree. A retiring employee may continue term life insurance coverage in the amount of $5,000, $10,000, or $20,000. To ensure coverage is continued, the retiring employee should apply at least 31 days prior to retirement, but no later than 31 days after losing coverage as an employee, and must make the appropriate premium contributions to continue coverage. This will be the retiring employee's only opportunity to continue coverage, as late retiree applications will not be accepted. Employees should contact their personnel office for forms and application instructions.

Cost of Coverage for Retired Employees

A retiree must pay the full premium cost for his coverage. Similar to retiree health insurance coverage provisions, the premiums for term life insurance must be deducted from the retiree's monthly Public Employees Retirement System (PERS) retirement benefit if the benefit amount is sufficient. Otherwise, the retiree will be billed the appropriate premium amount each month. The premium cost is actuarially determined and will vary based on the retiree's age and the benefit level selected.

Totally Disabled Employees

If a covered employee becomes totally disabled, he may be eligible to retain the same amount of term life insurance coverage he has as an active employee. The employee should apply at least 31 days prior to leaving employment as an active employee. If application is made more than 31 days after coverage as an employee has terminated, the right to apply for coverage as a totally disabled employee will be forfeited. To apply for continuation of coverage, the employee must complete a life insurance *Enrollment/Change Request Form*, a *Group Disability* claim form, and have his doctor complete an *Attending Physician's Statement*. Forms are available on the Plan's website at http://knowyourbenefits.dfa.state.ms.us, or may be obtained from the employee's personnel office. The employee should submit all three forms to his personnel office, which is responsible for providing additional information on the forms before sending them to the Mississippi Department of Finance and Administration's Office of Insurance. The Office of Insurance will likewise provide additional information and forward these documents to Minnesota Life for evaluation and a determination of disability. Additional medical information

supporting the disability claim may be requested from the employee by Minnesota Life. Minnesota Life will notify the employee, the employer, and the Office of Insurance of their decision. If the employee is approved by Minnesota Life for continuation of coverage as a totally disabled employee, the Office of Insurance will contact him with instructions on how to initiate his coverage. He will be required to make a one-time payment for the full premium amount for the first nine (9) months of life insurance coverage. After that, his premiums will be waived until he is deemed by Minnesota Life to be no longer disabled or reaches age 65, whichever comes first.

Minnesota Life is the sole authority for evaluating disability continuation of term life insurance coverage applications.

Naming a Beneficiary

A beneficiary is the person the insured chooses to receive his life insurance benefits. Instructions and/or forms for designating or changing a beneficiary may be found by accessing the Plan's website at http://knowyourbenefits.dfa.state.ms.us and clicking the link entitled **Life Insurance.** Employees and retirees who do not have internet access may contact Minnesota Life by telephone at (866) 293-6047 or the Department of Finance and Administration, Office of Insurance at (866) 586-2781 for information and assistance.

If more than one beneficiary is named, the insured should indicate how to divide the benefit among them in whole number increments to total 100%. If it is not indicated on the form how the benefit would be divided and the insured dies, the benefit will be divided equally among the named beneficiaries. Contingent beneficiaries may also be named if so desired. Benefits are payable to a contingent beneficiary if the primary beneficiary dies before the insured's date of death. If a beneficiary is not named as of the insured's date of death, Minnesota Life will pay the benefits in accordance with the policy's terms and conditions, in the following order:

1. the insured's lawful spouse, otherwise;
2. the insured's natural or legally adopted child(ren) in equal shares, otherwise;
3. the insured's parents in equal shares, otherwise;
4. the personal representative of the insured's.

Termination of Life Insurance Coverage

Life insurance coverage will terminate on the earliest of the following:

- The date the life insurance plan and/or group term policy with Minnesota Life terminates;
- The end of the month for which premiums have been paid;
- The end of the month in which the employee ceases to be employed or loses eligibility; or
- The end of the month following the date the insured elects in writing to terminate coverage.

NOTE: Retroactive termination requests are not permitted.

Portability to a Term Life Policy

Active employees participating in the group term life who subsequently terminate their State employment have the option to continue some or all of their term life insurance coverage through Minnesota Life. This provision allows qualified terminating employees to "port" to a term life insurance coverage, with no evidence of insurability requirements. To qualify, the participant must be under age 70, and his coverage termination in the group term life insurance coverage must be due to his employment termination, retirement, layoff or non-medical leave, or loss of eligibility (i.e., no longer a full-time employee). The participant must apply within 31 days from the date he loses coverage as an active employee. Medical evidence of insurability will not be required. The minimum amount of coverage for which a participant may apply to port is $10,000, while the maximum amount of ported coverage is limited to the actual amount of coverage that the employee is losing. A retiring employee may elect to port coverage, or continue group term life coverage as a retiree ($5,000, $10,000, or $20,000), or both, with the total amount of coverage not to exceed the amount of coverage he had as an active employee. A participant age 65 or older is limited to a maximum of 65% of the coverage he had as an active employee, with all such ported coverage to terminate at age 70. All premiums for ported coverage are the responsibility of the participant.

Benefits and provisions under the ported policy may not be the same as the group term life insurance. Employees should contact Minnesota Life for full details on the coverage available under portability and to request an application.

Converting to a Whole Life Policy

An employee may convert some or all of his group term life insurance to an individual whole life policy with Minnesota Life if:

- The employee leaves covered employment (including retirement) with the State of Mississippi or is no longer eligible for coverage; or
- The group term policy terminates and the employee has been covered for at least 5 years.

Application to convert coverage must be made within 31 days of the loss or benefit reduction of group term coverage. Note: Converting to an individual policy does not extend coverage under the life insurance coverage provided by the State.

Benefits and provisions under the converted policy may not be the same as this group term life insurance. Minnesota Life should be contacted for full details on the coverage available under conversion and how to apply for it.

Applying for Benefits – During the Conversion Period

If a person dies during the 31 days when he could have applied to convert or port to an individual policy, a claim may be made under this group term life insurance coverage by the beneficiary for the maximum amount for which an individual policy could have been issued. This right exists regardless of whether application for an individual policy had actually been made. If application for an individual policy had been made, the beneficiary designation on that application will be followed in the event the person dies during the conversion period.

Filing a Claim
Claims should be filed as soon as possible after a loss.

- **Employees:** The beneficiary or other interested party must submit a certified copy of the insured's death certificate to the employee's personnel office. The employee's personnel office is responsible for completing a *Notice of Death* form and submitting it, along with the certified copy of the death certificate and a copy of the employee's most recently completed *Enrollment/Change Request Form* to the Department of Finance and Administration, Office of Insurance. The Office of Insurance will verify coverage and the completeness of the claim and forward the appropriate documents to Minnesota Life for benefit processing.

- **Retirees and/or totally disabled employees**: The beneficiary or other interested party must submit a certified copy of the death certificate directly to the Office of Insurance. The Office of Insurance will verify coverage, complete a *Notice of Death* form, and forward the appropriate documents to Minnesota Life for benefit processing.

Additional information may be requested by the Office of Insurance or Minnesota Life in order to process a claim.

Note: Claims should not be filed directly with Minnesota Life, as this will only delay the process. All claims should be filed through the employer's personnel office or, if a retiree, directly with the Department of Finance and Administration, Office of Insurance.

Other State-Sponsored (Alternative) Life Insurance Policy
If an employer (school or community college) was approved by the State and School Employees Health Insurance Management Board to insure with a private group term life insurance policy instead of participating in the State and School Employees' Life Insurance Plan, several of the policies and procedures described above will not apply. Although the basic benefit structure and eligibility requirements must be the same as those provided in this coverage, certain enrollment and premium payment procedures will differ for those private policies.

If an employee is covered under an approved alternative State-sponsored policy, please note:

- Life insurance enrollment forms for private policies should be submitted by the personnel/payroll office to the private carrier – not to Minnesota Life.
- Participant change notifications should also be forwarded to the private life insurance company.
- Premiums are billed by, and should be remitted to, the private life insurance company, and should not be sent to the Department of Finance and Administration, Office of Insurance or Minnesota Life.
- Claims should be filed directly with the private life insurance company, not with the Office of Insurance or Minnesota Life.

BCBSMS does not maintain any information in its eligibility system regarding private life insurance policy participation. All communication and problem resolution activities relative to a private life insurance policy must be conducted between the employer and/or the employee and the insurance company.

If an employee is retiring from a district that participates in an approved alternative policy, he is eligible to continue coverage under the private policy as a retiree. Similar to this coverage, benefit levels of $5,000, $10,000, or $20,000 can be elected, and **the retiree will be responsible for the entire premium.** Arrangements must be made directly with the insurance company for payment of the premiums.

If the employer decides to drop the private policy, employees will be offered the opportunity to participate in the group term life insurance coverage through Minnesota Life. If an employee was participating in the private policy when it was dropped and chooses coverage with Minnesota Life, he will be considered a "new employee" and will not have to provide evidence of insurability. If an employee was not participating in the private policy when it was dropped and would like to apply for coverage with Minnesota Life, he will be considered a "late enrollee" applicant, subject to the evidence of insurability requirements.

Who to Contact

For claims information, call Minnesota Life at 888-658-0193 and refer to Group Policy 33683 - G. Minnesota Life should be contacted at 866-293-6047 for questions about the following:

- Beneficiary Designation
  Accidental Death and Dismemberment (AD&D) Benefits
- Policy Conversion
- Portability
- Any other information included in the *Your Group Plan* booklet

Note that Minnesota Life does not maintain specific information on insured individuals such as coverage amounts, current beneficiary designations, premium billings, etc.

The employee's personnel office or BCBSMS should be contacted for specific questions about the following:

- Premiums
- Coverage Amounts

Please note that to preserve confidentiality, specific coverage information will only be released to the insured individual upon appropriate identity validation. For questions regarding a private group term life insurance policy, the appropriate carrier should be contacted. Neither Minnesota Life nor BCBSMS maintains information on such policies.

Health Insurance Portability and Accountability Act (HIPAA)
Notice of Privacy Practices
State and School Employees' Health Insurance Plan

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review this Notice carefully.

This Notice relates to the State and School Employees' Health Insurance Plan only. This Notice does not apply to other covered programs offered by your employer, such as dental, vision, and flexible spending accounts. This Notice does not apply to non-covered programs such as life insurance and workers' compensation.

This Notice describes how the State and School Employees' Health Insurance Plan may use and disclose Protected Health Information (PHI) and also explains your legal rights regarding this information. Protected Health Information is individually identifiable information about your past, present, or future health or condition, health care services provided to you, or the payment for health services.

This Notice is effective on April 14, 2003.

The State and School Employees' Health Insurance Plan (Plan) is required by law to maintain the privacy of your PHI and to provide you with this Notice of the Plan's legal duties and privacy practices. The Plan is required to follow the privacy practices described in this Notice. This Notice is posted on the Plan's website at knowyourbenefits.dfa.state.ms.us. The Plan reserves the right to change its privacy practices and the terms of this Notice at any time. If a change is made to this Notice, a revised Notice will be mailed to those individuals defined as "enrollees" in the *Plan Document*. The revised Notice will be posted on the Plan's website. You have the right to receive a paper copy of this Notice upon request. You may request a paper copy of the Plan's HIPAA Notice of Privacy by contacting the Department of Finance and Administration, Office of Insurance, in the Jackson area at 601-359-3411, toll-free at 866-586-2781, or by writing to P.O. Box 24208, Jackson, MS 39225-4208.

PERMITTED USES AND DISCLOSURES
The examples of permitted uses and disclosures listed below are not provided as an all-inclusive list of the situations in which PHI may be used and disclosed by the Plan. However, the Plan will only use or disclose your PHI, without your written authorization, in situations falling into one of these categories.

Uses And Disclosures For Purposes Of Treatment, Payment, or Health Care Operations
The Plan may use and disclose your PHI for the purposes of treatment, payment, and health care operations. Examples of the uses and disclosures that the Plan may make under each purpose are listed below.

> **Treatment:** Refers to the provision of health care by a doctor, hospital, or other health care provider. The Plan generally does not use or disclose your PHI for treatment, but is permitted to do so, if necessary. For example, the Plan may disclose to your treating specialty provider the name of your treating general medical provider so that the specialty provider may have the necessary medical records to evaluate your medical condition.
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> **Payment**: Refers to the activities that the Plan undertakes in the payment of claims for covered services received by Plan participants. Examples of uses and disclosures under this section include determination of medical necessity of a treatment or service and what the allowable charge should be; determining if a treatment or service is covered by the Plan; and sharing PHI with insurers in order to settle subrogation claims and to perform coordination of benefits.
>
> **Health Care Operations**: Refers to the basic functions necessary to operate the Plan. Examples of uses and disclosures under this section include the use of PHI to evaluate the performance of the Plan's vendors; the disclosure of PHI to provide disease management programs to participants with specific health conditions; the disclosure of PHI to vendors under contract with the Plan who provide consulting, actuarial, claims review, and legal services to the Plan; the use and disclosure of PHI for general administrative functions such as responding to complaints or appeals; the use and disclosure of PHI for data and information management; and the use and disclosure of PHI for general data analysis used for planning, managing, and evaluation purposes.

Disclosures to the Plan's Business Associates
The Plan may disclose your PHI to its business associates as part of contracted agreements to perform services for the Plan, provided that the business associate agrees to protect the information.

Disclosure for Health Related Products and Services
The Plan or its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, the Plan's utilization management vendor may contact you regarding a disease management program.

Disclosures to Other Covered Entities
The Plan may disclose your PHI to other covered entities or business associates of those covered entities for the purposes of treatment, payment, and certain health care operations. For example, the Plan may disclose PHI to another health plan in order to perform coordination of benefits.

Other Uses and Disclosures Allowed Without Authorization
The Plan may use and disclose PHI, without your authorization, in the following ways;

- To you, as the covered individual;
- To a personal representative designated by you to receive PHI or a personal representative designated by law, such as the guardian ad litem for a minor or a person with power of attorney for health care;
- To the Secretary of Health and Human Services (HHS) or a duly designated employee of HHS as part of an investigation to determine the Plan's compliance with HIPAA;
- In response to a court order, subpoena, discovery request, or other lawful judicial or administrative proceeding or process;
- As required for federal, state, and local law enforcement purposes;
- As required to comply with Workers' Compensation or other similar programs established by law;
- To a health oversight agency for activities authorized by law such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee benefit programs, other governmental regulatory programs, and civil rights laws;
- As required to address certain matters of public interest as required or permitted by law. Examples include threats to the public health or national security matters; and
- To the State and School Employees Health Insurance Management Board, the Plan Sponsor, provided the appropriate language is included in the *Plan Document,* to carry out the payment and health care operations functions discussed above.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI will only be made upon receiving your written authorization. If you have provided an authorization to the Plan, you may revoke your authorization at any time by providing written notice to the Plan. The Plan will honor a request to revoke as of the day it is received and to the extent that the Plan has not already used or disclosed your PHI.

YOUR RIGHTS IN RELATION TO PROTECTED HEALTH INFORMATION

The federal privacy regulations give you the right to make certain requests regarding your PHI.

Right to Request Restrictions

You have the right to request that the Plan restrict its uses and disclosures of PHI in relation to treatment, payment, and health care operations. Any such request must be made in writing and must state the specific restriction requested and to whom that restriction would apply. The Plan is not required to agree to a restriction that you request.

Right to Request Confidential Communications

You have the right to request that communications involving your PHI be provided to you at a certain location or in a certain way. Any such request must be made in writing. The Plan will accommodate any reasonable request if the normal method of communication would place you in danger and that danger is stated in your request.

Right To Access Your Protected Health Information

You have the right to inspect and copy your PHI maintained in a "designated record set" by the Plan. The designated record set consists of records used in making payment, claims adjudication, medical management, and other operations. The Plan may ask that such requests be made in writing and may charge reasonable fees for producing and mailing the copies. The Plan may deny such requests in certain cases.

Right to Request Amendment

You have the right to request that your PHI created by the Plan and maintained in a designated record set be amended. Any such request must be made in writing and must include the reason for the request. If the Plan denies your request for amendment, you may file a written statement of disagreement. The Plan has the right to issue a rebuttal to your statement, in which case, a copy will be provided to you.

Right to Receive An Accounting of Disclosures

You have the right to receive an accounting of all disclosures of your PHI that the Plan has made, if any. This accounting does not include disclosures for payment or health care operations or certain other purposes, or disclosures to you or with your permission. Any such request must be made in writing and must include a time period, not to exceed six (6) years. The Plan is only required to provide an accounting of disclosures made on or after April 14, 2003. If you request an accounting more than once in a 12-month period, the Plan may charge you a reasonable fee.

All requests listed above should be submitted in writing to the Department of Finance and Administration, Office of Insurance.

COMPLAINTS

You have the right to file a complaint if you think your privacy rights have been violated. You may file a complaint with the Plan by writing to the Department of Finance and Administration, Office of Insurance, Attention: Privacy Officer at the address listed in this Notice. You may also file a complaint by writing to the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

PRIVACY CONTACT

If you have any questions regarding this Notice, please contact the Department of Finance and Administration, Office of Insurance by mail at P. O. Box 24208, Jackson, MS 39225-4208 or by phone in the Jackson area at 601-359-3411, or toll-free at 866-586-2781.

Important Notice from the Mississippi State and School Employees' Health Insurance Plan
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Mississippi State and School Employees' Health Insurance Plan (Plan) and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **If you are both eligible for Medicare and you are covered by the Plan *other than* as a retiree, a surviving spouse, or a dependent of a retiree or a surviving spouse, the State and School Employees Health Insurance Management Board has determined that the prescription drug coverage offered by the Plan is, on average expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.**

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiary's leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your coverage under the Plan, be aware that you and your dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with the Plan and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact Blue Cross & Blue Shield of MS Customer Service at 1-800-709-7881. NOTE: You may receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the Plan changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Name of Entity/Sender:Department of Finance and Administration, Office of Insurance
Contact--Position/Office:Blue Cross & Blue Shield of MS
Address:P. O. Box 23071, Jackson, MS 39225-3071
Phone Number: 1-800-709-7881